UNIVERSITY OF ALBERTA

Becoming Self-Sufficient:

The Experience of Iranian Immigrants who Access Canadian Health Care Services

By

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DEDICATION

To all of the displaced, strong people in the world

To all Iranian refugees and immigrants

To my parents, with my deepest love and gratitude for all the support they have given to me throughout my life

ABSTRACT

Canada is home to people from various cultural groups who speak languages other than English or French. Iranians comprise an immigrant group that has a very different cultural background from that of the mainstream Canadian population and speaks a language other than English or French, in this case mainly Persian (Farsi). More than 103367 Iranian immigrants live in Canada. For these reasons, research with Iranian newcomers is useful for learning about strategies that immigrants develop to access health care services.

The research question guiding this study was, "What are the processes by which Iranian immigrants learn to access health care services in Canada?" To answer this question, the author applied a constructivist grounded theory approach. Unstructured and semistructured interviews were conducted with 17 first-generation Iranians (11 women and 6 men) who were adults (at least 18 years old) and who had immigrated to Canada within the past 15 years. Findings suggested that although language was a key factor, appropriate, effective, acceptable, and responsive facilities and services played an important role in Iranian immigrants' accessing health care services. The processes of accessing health care services, becoming self-sufficient, and being integrated were complex and reciprocal, suggesting that self-sufficiency in access to health care may be perceived as an indicator of integration. In addition to commonly employed resources for accessing health care services, Iranians received considerable help from the public library, librarians, and the Internet. They considered these to be the most helpful resources.

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CHAPTER I: INTRODUCTION

Immigrant Populations and Health Care Services

Immigration is not a new phenomenon but rather has deep roots in human history. There are many documents from every era detailing individuals who left their homelands and struggled to reestablish their lives in other countries. Because immigrants comprise a significant percentage of the Canadian population and are less likely to come from Europe than in the past, our society has become more recognizably ethnically diverse in recent years (Masi, Mensah & McLeod, 1995, 1996). This diversity has reciprocal effects on the immigrants themselves and on the host society with respect to culture, including ways of living, values, beliefs, and languages. Maintaining health and accessing appropriate health services as needed are challenges faced by all newcomers. In this dissertation, the specific issues identified by Iranian immigrants and refugees are explored using a grounded theory research approach.

Background to the Problem

Immigration to Canada

During the years 1900 to 1915, one in five Canadians was identified as foreign born. A significant shift has taken place in the ethnic backgrounds of individuals immigrating to Canada since the early 1900s. By 1991, the immigrant population represented only 16% of Canada's population. Canada's two official languages, English and French, are the mother tongues of 59.7% and 23.2% of the population, respectively (Statistics Canada 2005 modified in 2006). According to Statistics Canada (2004), about 48.6% of permanent residents (immigrants) speak English, 4.8% speak French, 9.6% speak both official languages, and 37.0% speak neither English nor French; in Alberta

about 56.6% of permanent residents speak English, 0.9% speak French, 4.2% speak both official languages, and 38.3% speak neither English nor French.

Canada is a very ethnically diverse country. In 1986, Canada was home to people from 80 cultural groups who spoke approximately 100 languages (Chan, 1995). According to the 2001 census, which has its way of identifying ethnicity, Canada is now home to 34 ethnic groups with over 100,000 members in each group. At present, Canadian immigrants come from many locations, with varied ethnic, linguistic, socioeconomic, and political backgrounds (Statistics Canada, 2006).

In 2004, Canada's sponsorship program brought about 2,210 refugees to Alberta (Statistics Canada, 2004), presenting a significant challenge to those in the health care system (Masi et al., 1995, 1996).

Iranian Immigrants in Canada

Immigration from Iran is not as widespread as it is from other countries, but it has grown as a result of the Islamic revolution, American political and economic sanctions, the Iran-Iraq war, and other socioeconomic issues. Thousands of Iranian families have been displaced to other countries, mostly in North America and Europe, and some have chosen Canada. Hafizi (1998) and Jalali (1982) stated that immigration from Iran to the United States occurred in three waves.

The first wave occurred between 1950 and 1970. Immigrants in this category were mainly highly educated, middle-class groups with professional backgrounds or students. Those who came in the second wave of immigration from 1970 to 1978 were from a higher socioeconomic group, compared to the first wave, because of the economic boom and rapid growth that had taken place in Iran. Their reasons for migrating were

more diverse. Some individuals sought better economic opportunities while others came in search of better and more educational opportunities. Immigrants from the second wave remained in the same social class that they had enjoyed in Iran.

The third wave started in 1979, following the revolution, and continues to the present (Behjati-Sabet, 1990; Behjati-Sabet & Chambers, 2005; Hafizi, 1998; Jalali, 1982; Shahideh, 2004). Many of these individuals left Iran because of the revolution, political issues, and personal security. This group is very diverse with respect to its socioeconomic and educational background. Many people in this group experienced extreme culture shock. They suffered from extreme feelings of frustration and depression following their attempts to adjust to a foreign culture and language (Bagheri, 1992; Bejati-Sabet 1990; Behjati-Sabet & Chambers, 2005; Dilmaghani, 1999, 2001; Dossa, 1999, 2001, 2002; Emami & Ekman, 1998; Emami, Benner, & Ekman, 2001; Emami, Torres, Lipson, & Ekman, 2000; Hafizi, 1998; Jalali, 1982; Karimi Moghari, 2003; Lipson, 1992; O'Shea, 2000; Pliskin, 1987; Waxler-Morrison, Anderson , & Richarson, 1990, 2005). As well, there are Iranian immigrants who have come to Canada as international students for better education and then have stayed as immigrants. Because of economic instability, some wealthy Iranians working in private or governmental sectors immigrated to Canada mainly as investors or as skilled workers. These two last groups enjoy a lifestyle in Canada similar to their lifestyle in Iran. Since they do not have political issues with the present government or financial limitations, they do not have much problem going back and forth to Iran. Therefore, they are not faced with issues that other immigrants and refugees must address.

Before 1961, about 130 Iranians settled in Canada, but this number has grown (Citizenship and Immigration Canada, 1966 & 2005) (See Table 1, p.5 and Table 2, p. 6). In 2001, the total population of Iranians in Canada was 75,000 (71,980 immigrants and 3,020 nonpermanent residents), with 42,315 in Ontario, 18,450 in British Columbia, 7,535 in Quebec, 2,400 in Alberta, and 1,280 in the rest of Canada. In 2001, 865 Iranians lived in Edmonton (840 immigrants, 25 nonpermanent residents), and 1,520 lived in Calgary (1405 immigrants, 15 nonpermanent residents) (Statistics Canada, 2002). According to Statistics Canada (2004), about 6,063 Iranians live in Alberta.

Immigration, Health, and Health Care

Immigration is associated with a number of factors that have a negative effect on health. According to Health Canada (2004), there is growing evidence of a positive relationship between health status and factors such as income and social status, social support networks, education and literacy, employment/ working conditions, social environments, physical environments, personal health practices and coping skills, child health development, biology and genetic endowment, health services, gender, and culture. Immigrant and refugee populations frequently experience low socioeconomic status, limited social support networks, lower education, and unemployment or poor working conditions and demonstrate personal health practices and coping skills that compromise their health status.

Structural and social barriers to health care services in North America, even among North Americans, have been well documented (Leclere, Jensen, & Bilddlecom, 1994). In addition to these problems, immigrants deal with a number of additional hurdles, due to their lack of language proficiency, cultural differences, lack of

Table 1

Iranian Permanent residents in Canada (1961-2005)

YEAR	NUMBER
>1961	130
1961-1970	620
1971-1980	3455
1981-1990	20700
1991-1995	15990
1996-2001	37366
2002-2005	25106

Adapted from Citizenship and Immigration Canada (1966-1996 & 1998-2005)

Table 2

Iranian Permanent Residents in Canada (1995-2005 per year)

Year	Number	Percentage*	Percentage**	Rank***	Rank****
1995	3,692	11.2	1.7	1	15
1996	5,833	16.0	2.6	1	9
1997	7,489	19.8	3.5	1	7
1998	6,775	20.8	3.9	1	7
1999	5,907	17.6	3.1	1	6
2000	5,608	13.7	2.5	1	8
2001	5,740	11.9	2.3	1	7
2002	7,738	17.0	3.4	1	5
2003	5,648	12.9	2.6	1	7
2004	6,063	12.2	2.6	1	6
2005	5,502	11.2	2.1	1	9

Adapted from Citizenship and Immigration Canada (2005)

* Percentage of permanent residents by top source countries

** Percentage of permanent residents from Africa and the Middle East by top source countries

*** Rank among permanent residents by top source countries

**** Rank among permanent residents from Africa and the Middle East by top source countries

information, or misinformation, all of which limit their access to health care services (Anderson, Tang & Blue, 1999; Bergin, 1988; Chang & Fortier, 1998; Didukh, 2001; Dossa, 1999; Dunn, 1998; Dunn & Dyck, 1998; Fadiman, 1997; Fowler, 1998; Globerman, 1998; Nerad & Janczur, 2000; Schall, 1986; Timmins, 2002; Walker & Jaranson, 1999; Yuan, Rootman, & Tayeh, 1999).

Immigrants are often considered difficult patients because of language and cultural barriers. As a consequence, they feel frustrated and avoid contact with health care services or seek treatment only when symptoms become acute (Dillmann, Pablo & Willson, 1995; Ellis 1982; Schultz, 1982). Delayed treatment might aggravate and exacerbate existing health problems (Dillmann et al., 1995).

To prevent the occurrence of such problems, health professionals must acknowledge that individuals from countries with different cultural, ethnic, and linguistic backgrounds must be viewed differently and with respect. Dillmann et al (1995) suggested that despite the reality of the multicultural nature of Canada, health care providers do not fully understand the impact of culture on health. Thus, it is not surprising that immigrants and refugees experience difficulty obtaining access to health care services.

Many local and national studies have been conducted in Canada regarding immigrant populations who speak no English or French and who have special health problems and social needs. Bergin (1988) identified the importance of studying the process by which these groups access health and social services, including strategies by which they obtain the information they need to gain access to these services. Bergin, noting work undertaken by researchers based in Toronto, reported,

> Most studies emphasize a "needs analysis" or alternatively, focus on the "availability of services". Although many of those studies claim to be dealing with aspects of "access" or "accessibility", their findings were oriented to the problematic [sic] of "availability"... Minority ethnic group clients encounter problems common to all users of the health and social service delivery systems...These problems are more acute, however, for minority ethnic group clients who experience other difficulties in gaining access... Communication is a fundamental barrier that impedes the full development of access. Obstacles include lack of information; styles, techniques and strategies of communicating; the unavailability of services; and a lack of knowledge and understanding on the part of service providers about the linguistic and cultural factors which complicate delivery patterns. (pp.10-11)

A specific example of newly arrived German immigrants illustrates these points. Schall (1986) reported that 45% of elderly, German-speaking immigrants in Canada had major medical problems and that more than 70% had suffered from these problems for more than a year. She found that although many of them knew of available services, they did not know how to use them.

It is assumed that Canadian health and social service organizations are ready to serve all those in need, Canadian-born or immigrants. Although in theory immigrants have the same right to all services as members of the dominant majority (Romanow, 2002), the system has not achieved this goal (Bergin, 1988; Dillmann et al., 1995). Consequently, diagnosis and treatment often occur later in the disease trajectory.

My Connection to the Issues

I chose to study the process by which Iranian immigrants access health care in Canada for several reasons. I am from Iran, came to Canada in 1999, and am fluent in both Persian (Farsi) and English. Thus, I was able to interview participants in either language, reducing language barriers and potential for misunderstanding. The idea for this study originated years ago while I was working in a hospital and taking care of patients who had little or no knowledge of English.

As a practicing nurse, I had the opportunity to observe Iranian immigrants admitted to various hospitals, and occasionally was called upon to help solve health care problems because I spoke Persian (Farsi). Many times, I was asked to go to different units or to the emergency department to help physicians or staff communicate with Iranian or Afghani clients.

The fact that these immigrants had a difficult time accessing or using the available health care services persuaded me to investigate some possible ways to help health care providers and policy makers reduce this inconsistency. I hoped that by studying how Iranian immigrants learn to use the health care services in Canada, I could develop a foundation for studying other immigrants as well. Eventually, I would like to develop a theory that could be used to guide the development of strategies that could facilitate access to health care services by immigrants.

Purpose of the Study

Immigrants encounter stress when trying to build a new life in their host countries, and this stress frequently leads to illness. To obtain service from the health care system, individuals must know how to access it. The goal of this study was to learn more

about the processes by which Iranian immigrants learn to access health care services in Canada. Based on findings, I have proposed strategies to provide better access to health care services for individuals with cultural differences and language barriers.

Statement of the Problem

Although health care providers' mission in Canada, as a pluralistic society, is to provide care to individuals from a broad range of cultural backgrounds and languages that are different from their own, little research has been done in this area. As immigrant populations are frequently targeted for health promotion programs, the health care researcher's job is to identify barriers to health care services, find out how these barriers are framed, identify related research requirements, and determine how research findings can be used to guide practice (MacKinnon, Howard & Larkin, 1998). As Aujlay (2001) has stated, "If we keep on ignoring minorities in Canada, we will have no one to blame, except ourselves" (p.1).

Definition of Terms

Practically, there are different types of immigration in Canada. Documented or legal immigrants are those who have been granted permanent residence. Undocumented immigrants are those who come to the country legally but with a student, visitor, or business visa, overstay in the host country, and change their condition to that of landed immigrants. Refugees have been forced to leave their homelands as a result of racial, religious, or political persecution and so are considered involuntary immigrants (Statistics Canada, 1991). My clinical experience suggests that refugees are very reluctant to admit their refugee status and that they refer to themselves as immigrants. Behjati-Sabet (1990) mentioned that Iranians are reluctant to admit their refugee status. Thus, in this study, I

will use the term *immigrant* to refer to both *immigrants* and *refugees*.

Immigrants are ethnically different from mainstream society. Ethnicity has been defined as a shared heritage that forms individuals' identities based on "descent, language, religion, beliefs, tradition and other experiences" (Weber, 1968, p. 388). The term *minority groups* refers to a group of people that "regardless of size, is distinguishable on the basis of color, language, culture, sex, religion, or other recognizable features" (p. 94) and has less power over societal decision-making and unequal access to opportunities (King & Williams, 1996).

Access refers to entering into a place, or the right or opportunity to use something (Kipfer 2006). Andersen and Davidson (2001) defined access as

> ... actual use of personal health services and everything that facilitates or impedes their use. It is the link between health service systems and the populations they serve. Access means not only getting to services but also getting the right services at the right time to promote improved health outcomes. (p. 3)

Jourdain (2000) defined access as the ability to use resources to address a health need as well as to maintain health. In this study, I am adapting Andersen and Davidson's (2001) and Jourdian's (2000) definitions of access in terms of the right services at the right time as well as the ability to use resources to address self-defined health needs, in order to maintain health and promote health outcomes.

Research Question

Although some researchers have studied the effect of immigration on health and access to health care services, Canadian health services are far from providing full access to health care for immigrants (Falk, 1995). There is a need for more research on strategies that could increase accessibility to the Canadian health care system for immigrant populations. Identification of the process of seeking health care services on the part of Iranian immigrants, a growing group among immigrants to Canada, will help address this gap. The research question in this study was, "What are the processes by which Iranian immigrants learn to access health care services in Canada?"

CHAPTER II: LITERATURE REVIEW

There are different views regarding the role of a literature review prior to undertaking a qualitative study. Strauss (1987) asserted that it is appropriate to consult the literature to gain general knowledge of the topic, to enrich the study, and to trigger broader and deeper theorizing. In addition, Field and Morse (1985) suggested that a preliminary analysis of the literature after each interview could guide successive data collection and direct the researcher's line of inquiry. In contrast, Glaser (1998) and Hutchinson (1986, 1993) stated that normally a literature review should not be done in substantive and related areas in which the study will be done. Rather, the literature review should be done during final saturation of codes, categories, and constructs, and just before writing about the theory. However, Glaser (1998) added that there are two conditions that require a pre-research literature review— when writing theses and grant applications.

As suggested by Glaser (1998), I briefly reviewed literature in the substantive areas related to the impact of immigration on health and access to health care services before doing interviews. Much research regarding immigrants has concentrated on psychiatric issues, such as posttraumatic stress disorder (PTSD), depression, mental disorders, mental health, suicide, stress, and adaptation or coping (Aroian, 1990, 1993; Aroian & Patsdaughter, 1989; Bagheri, 1992; Budman, Lipson, & Meleis, 1992; Chung & Kagawa-Singer, 1993, 1995; Dossa, 1999; Flaskerud & Anh, 1988; Franks & Faux, 1990; Frye & McGill, 1993; Hattar-Pollara & Meleis, 1995; Laurence, 1992 a, 1992b; Lipson, 1993; Lipson & Meleis, 1999; Muecke & Sassi, 1992; Stein, 1986; Williams & Berry, 1991).

Other researchers have studied acculturation, assimilation, concepts of health, health status, poverty, race, gender, parenting, structural barriers, lifestyle choices, ethnicity, and lack of cultural competence (Ailinger & Causey, 1995; Anderson, 1985; Behjati-Sabet, 1990; Boyle, 1989; Cheon-Klessige, Camilleri, McElmurry, & Ohlson, 1988; Dempsey & Gesse, 1983; Hattar-Pollara & Meleis, 1995; Hatton & Webb, 1993; Kulig, 1990; Lipson, 1991, 1992; Lipson, & Miller, 1994; Lynam, 1985; May, 1992; Meleis, 1991; Meleis, Lipson, & Paul, 1992; Meleis, Omidian, & Lipson, 1993; Omidian & Lipson, 1996; Park & Peterson, 1991; Pickwell, 1996). Only a few studies have addressed immigrants' and refugees' access to health care services (Berk & Schur, 2001; Derose, 2000; Remennick, 2003).

The more updated and in-depth literature review was done during and after analyzing data. More literature was reviewed to explain the finalized theory (Glaser & Strauss, 1967). Additional literature pertaining to the emerging theory is included in the discussion chapters and formed the basis for my recommendations regarding strategies for promoting better access to Canadian health services for Iranian immigrants.

Theoretical Perspectives on Access to Health Care

Accessibility and Utilization

To create better access to health care services, scholars such as Gross (1972), Penchansky (1977), Tanahashi (1978), Khan and Bahrdwaj (1994), and Gold (1998) have designed various access models, but the Andersen (1968) behavioral model of health services is one of the most popular models applied in studies about using and accessing health care services. For this reason the Andersen Model is discussed in the greatest detail.

The Andersen Behavioral Model

The behavioral model of health services was designed primarily by Ronald Andersen (1968) as a part of his doctoral dissertation. It was followed by six revisions that incorporated a few refinements and improvements (Aday & Andersen, 1974; Andersen, 1995; Andersen & Davidson, 2001; Andersen, Marcus, & Mahshigan, 1995; Andersen & Newman, 1973; Andersen, Smedby, & Andersen, 1970). The goals of this model were to improve understanding of the contributing factors to access to health care services.

Initially, the behavioral model's focus was on the use of health services (Aday & Andersen, 1974) but in the fourth revision its emphasis switched to access (Andersen et al., 1995). The most recent version of the behavioral model consists of new components and more links and feedback loops (Andersen & Davidson, 2001). Many researchers have used this model to understand, explain, and develop the concept of access in health care services.

Andersen (1968) hypothesized that "the use of health services was the result of a complex, interrelated set of factors" (p. 10). He suggested that health services use results from a combination of three components; predisposing, enabling, and need. The predisposing component has family composition, social structure, and health beliefs as variables. Andersen believed that the use of health services is more likely to be a family behavior but that this behavior is not "directly responsible for health services use" (p. 15). Family composition variables included age, sex, family size, the age of the youngest and oldest family members, and the marital status of the head of the family. Social structure variables consist of physical and social environmental factors, such as employment

status, occupation, social class, education, race, and the ethnicity of the head of the family. Health beliefs variables included the family head's beliefs about health, health insurance, physicians, and disease. The enabling component allowed a family to take action and use services. The economic resources and source of medical care made up the family resources variables. Community resource variables included the availability of health care services, such as the ratio of physicians to population, the ratio of hospital beds to the population, and geographical accessibility to health care services. Need included the family's perception of illness and its response to it. Illness variables were self-reported. Andersen pointed out the importance of the relationship between the components in determining and producing use. He hypothesized that the closer the component is to the outcome of health services use, the higher the expected correlation between the component and use. Therefore, need was the most prominent component and the strongest contributor in explaining and predicting health care use, the enabling component ranked as second in importance, and the least influential component would be the predisposing component.

The first revision of the behavioral model resulted from an investigation of differences in health services use between the United States and Sweden (Andersen et al., 1970). Andersen and colleagues introduced the system model consisting of two main components of health delivery: resources and organization. Resources were composed of the volume of the resources and their geographical distribution. Distribution referred to resource availability by geography within a health care system. The organization of the health care system included access and structure. In this model, Andersen et al. (1970) defined access as,

> the means through which the patient gains entry to the medical care system and continues the treatment process. It specifies the requirements that must be met and the barriers which must be overcome before medical care is received. The degree of access in any system varies according to such things as direct out-of-pocket cost for medical care to the patient, the length of the queue for various kinds of treatments and general definitions concerning conditions which qualify the patient for treatment. Accessibility is assumed to increase as the proportion of medical care expenditures paid for by the government, voluntary health insurance, or other third-party payers increases, as the waiting time for medical care decreases, and as the range of conditions accepted for treatment increases. (pp. 7-8)

Andersen et al. (1970) defined structure as the arrangements after an individual enters the health care system. They described structure as very complex and related to referral patterns, the provider approach, and hospital care characteristics, but also overlapping somehow with the definition of access. They pointed out, "Access as we defined it depends in part on structure, and the structure of any system is dependent on the resources available to it" (p. 81).

Andersen et al. (1970) hypothesized that the greater the volume of health resources, the greater the distribution of health resources, or the higher the third-party payment for health care services, the greater the health services utilization will be. They introduced testable hypotheses for volume, distribution, and access, making three main changes to the original behavioral model. First, the individual, rather than the family,

became the unit of analysis. Second, they eliminated the health beliefs predisposition subcomponent. Third, they thoroughly revised the need component. Their study showed that in a health care system with high accessibility, social structure-predisposing subcomponents and enabling components were less important. Andersen and colleagues conducted separate detailed analyses on both the system model and the behavioral model and found that some hypotheses were supported and some were not. Therefore, they did not suggest any revisions to this model based on their results. They asked other researchers to apply their model, which can be used, altered, and expanded, as a general framework for international comparison studies. Andersen and colleagues (1970) claimed that their model was a "helpful device for comparing how health services systems are used by people in different countries" (p. 122). Research suggested that there was a significant difference between the process of entry into a health care system and the process of receiving services once in the system. Following this, they suggested that the behavioral model should consist of two dimensions – an entry dimension and a service received dimension – with their own outcome measures.

Andersen and Newman introduced the second revision of the original model in 1973. This model had a new dimension of societal determinants, an individual determinant subcomponent of evaluated illness, components for use, and the concept of the degree of mutability of predisposing and enabling components. The societal determinants dimension was made up of components such as technology and norms. In addition, societal determinants influenced health service utilization through the individual determinants and health services system pathways.

Following a national survey on access to care and to provide a systematic basis for assessing the performance of governmental and private programs in increasing access to medical care in the United States, Aday and Andersen (1975) revised the second model, placing more stress on the access model than on the utilization model, although they did not define access explicitly. In this model, they suggested that utilization of health services is influenced by health policy as an input or starting point through different pathways, such as the characteristics of the health delivery system dimension and the characteristics of the population at risk. The characteristics of the population at risk dimension could be influenced by the characteristics of the health delivery system dimension. The characteristics of the population at risk dimension could influence utilization directly or through the consumer satisfaction dimension. The consumer satisfaction and utilization of health services dimensions influenced each other (Aday & Awe, 1997).

Andersen et al. (1995) published the fourth revision of the behavioral model in a dental disease prevention and oral health promotion textbook. The focus of this model was on "comparing the preventive orientation of oral health care systems" (p. 310) rather than access. In this model, use was not an outcome. They suggested that use was a component of an intermediate dimension, called health behavior, between primary determinants of health as inputs and health outcomes as outputs.

Andersen introduced the fifth version of the behavioral model in 1995. In this model, he provided four formal access measures rather than focusing on access per se. He defined measure of access as potential access ("the presence of enabling resources"), realized access ("actual use of services"), equitable access ("when demographic and need

variables account for most of the variance in utilization"), and inequitable access ("when social structure such as ethnicity, health beliefs, and enabling resources such as income determine who gets medical care") (pp. 4-5). He also added two more access measures based on his previous model (Andersen et al., 1995): effective access, defined as "use of health services leading to improved health status or improved satisfaction," (p.6) and efficient access, defined as "improving health services use outcomes at least cost" (p. 6).

Andersen and Davidson (2001) introduced the most recent revision of the behavioral model, which provides an in-depth definition of access. They defined access as,

> actual use of personal health services and everything that facilitates or impedes their use. It is the link between health services systems and the populations they serve. Access means not only getting to service but also getting to the right services at the right time to promote improved health outcomes. (p. 3)

Andersen and Davidson (2001) connected access to three health policy objectives: health services use; social justice; and the efficiency and effectiveness of health service delivery. They also introduced contextual characteristics, individual characteristics, health behavior, and outcomes into their model. Contextual characteristics were divided into predisposing components, including: demographic factors and social and beliefs subcomponents; enabling components, including health policy, financing, and organization subcomponents; and need components, such as the environment and population health indices. Individual characteristics consisted of predisposing, enabling, and need components. Predisposing components included demographic factors and social

and beliefs subcomponents. Enabling components contained financing and organization subcomponents, and need components included perceived and evaluated subcomponents. The health behaviors dimension included personal health practices, the process of medical care, and the use of personal health services components. The outcome dimension consisted of perceived health, evaluated health, and consumer satisfaction components.

Gross Access Model

Gross (1972) developed a model that was based on the original Andersen behavioral model (1968). He combined accessibility factors with predisposing components, enabling components, and perceived health variables. He explained that accessibility factors included: geographical variables, such as the distance to the nearest health facility; time variables, such as appointment waiting times; and general variables, such as the availability of a regular source of care. Gross hypothesized that predisposing health beliefs and enabling family and community resources influence health care use.

Tanahahsi Access Model

In 1978, Tanahashi designed an access model called Tanahashi's coverage stages. In this model, coverage referred to the relationship between the health care system and the individuals supposed to be served by it. The emphasis of this model was on the interaction between the system and the individuals based on the five stages of a hierarchy: availability coverage (the capacity of available resources and the amount of available services offered to a population); accessibility coverage (the number of people

who can use the services); acceptability coverage (the willingness of service use); contact coverage (the number of people who actually use the health care services), and effectiveness coverage (people who received effective health care).

Penchansky Access Model

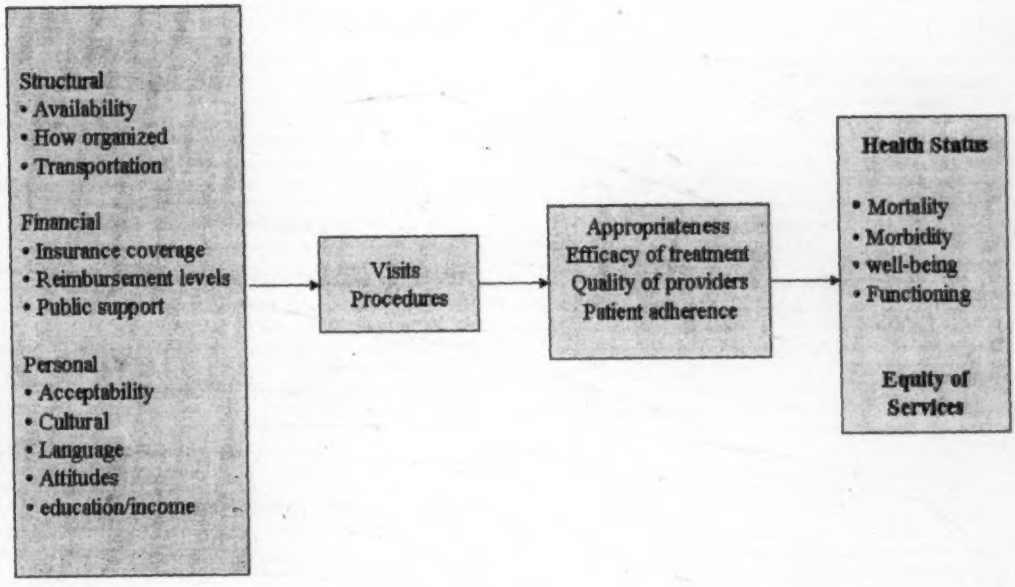
Penchansky (1977) introduced a model of access based on the fit between the health care system and its users. He hypothesized that services utilization, patient satisfaction, and provider practice patterns are influenced by the degree of the fit via five dimensions: availability; accessibility; accommodation; affordability: and acceptability (Penchansky, 1977; Penchansky & Thomas, 1981). He defined availability as the relationship between health care services and resources and the users' needs, such as the adequacy of the supply of physicians. Accessibility referred to the relationship between the users and geographical resources, such as the time needed to travel to care. Pechansky defined accommodation as the relationship between the organization of resources and the users' ability to adjust to this organization, such as physicians' office hours. Affordability referred to the relationship between the users' ability to cover the cost out of pocket or through insurance payments and the price of services or the design of insurance. Acceptability was defined as a mutual willingness of providers to interact with users, such as the availability of a female gynecologist. Penchansky defined access as the interaction between health care users and health care supply, rather than taking all factors that influence use into account.

Institute of Medicine Access Model

The Institute of Medicine (IOM) defined access as "the timely use of personal health services to achieve the best possible outcomes" (Millman, 1993, p. 33). It claimed that integrating service use and outcomes reveals a better picture of access problems. Structural barriers were defined as "impediments to medical care directly related to the number, type, concentration, location, or organizational configuration of health care providers" (p. 39). Financial barriers restrict patients' ability to pay for their medical services. Personal/language and cultural barriers "may inhibit people who need medical attention from seeking it" (p. 39) or cause them to ignore following up on health care providers' recommendations. Since the model developed in my study was most similar to the IOM model, a diagram of the model has been included to facilitate the discussion in Chapter 6 (See Figure 1, p. 24).

The IOM believed in individual participation in the health care system (Millman, 1993). They indicated that structural, financial, and personal barriers were responsible for access problems, followed by decreasing service use, poor health outcomes, and inequity in services use and health outcomes. They illustrated that barriers interacted with each other to produce a general effect on access and claimed that although mediating factors (the appropriateness and efficacy of treatment, the quality of providers, and patient adherence) were not related to barriers to access to services, they influenced health outcomes and equity in service use.

Figure 1. Institute of Medicine Framework for Access (Millman, 1993)



Khan and Bhardwaj Access Model

Khan and Bhardwaj (1994) introduced their own model of access, although they used the Aday and Andersen (1974) model to describe health policy, the health care system, and potential users of the system. Khan and Bhardwaj mapped their model with a double-headed arrow between the health care system and users, as opposed to the unidirectional arrow designed by Aday and Andersen. They also emphasized concepts such as potential access and realized access. Realized access referred to utilization. Potential access referred to the availability of health care resources and was influenced by the characteristics of the health care system. Potential access led to realized access through facilitators and barriers. The characteristics of the health care system and of potential users influenced facilitators and barriers. Khan and Bhardwaj hypothesized that potential and realized access contribute to present access, which they described as the degree/level of services as well as the spatial (social) and aspatial patterns of service availability and service use. Present access could be either adequate/satisfactory or inadequate/unsatisfactory. Khan and Bhardwaj hypothesized that knowledge of the variables associated with the satisfactory/adequate access would help policy makers to improve future access.

Gold Access Model

Gold (1998) built his model based on the Institute of Medicine Access Model (Millman, 1993) but replaced structural, financial, and personal barriers under the determinants of plan selection followed by health plan and delivery system and the

determinants of continuity of enrolment. Gold's access model was applied only in the United States during managed care's peak.

Access Theories: Some Criticisms

A number of authors have criticized the existing access models. Pescosolido and Kronenfeld (1995) noted that the models are too static and thus do not accommodate change over time in the lives of immigrants. Penchansky (1997) noted that the models are too broad to be of any practical use.

Several groups of authors have criticized the models for their lack of emphasis on provider variables (Kronenfeld, 1980; Thomas & Penchansky, 1984; Zambrana, 1987). Other authors have noted that existing models fail to account for the actual interaction been immigrants and the providers of health care services (Bass, Looman, & Ehrlich, 1992; Gold, 1998; Guendelman, 1991; Houle, Salmoni, Pong, Laflamme, & Viverais-Dresler, 2001; Mechanic, 1979; Porter, 2000; Portes, Kyle, & Eaton, 1992).

Many other factors that influence individuals' access to heath care services are not addressed in the existing models including unequal power, language/communication barriers, cultural differences, limited finances, differences in health care systems, and limited knowledge of new services. Such factors may make immigrants feel that they are being discriminated against, which may contribute to lack of use of health care services. Therefore, existing models of health care access may be limited in terms of their applicability to immigrant populations.

As Romanow (2002) pointed out, the *Canada Health Act* represents "both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care" (p. 60). It seemed to Romanow that of

the five basic principles, accessibility and universality are the most necessary and "confirm the conviction of Canadians that essential health care services must be available to all Canadians on the basis of need and need alone" (p. 61). By definition, the principle of accessibility represents that there should be no barriers to health care services, and the principle of universality implies that provincial and territorial health insurances cover all Canadians in the same way and equally. We have to be sure that we serve all individuals.

Nursing Research on Immigration

Muecke (1990) surveyed nursing research on immigrants and refugees but could not find any studies before 1981. She reported that by 1989 research had been conducted by nurses on immigrants and refugees mainly among Indochinese populations. The primary focus was on maternal-child and public health. She stated that by 1996, nurses had become interested in other topics, such as cultural beliefs, women's childbearing roles, mental health, and issues related to torture, and in more diverse populations, such as Cambodians, Chinese, Hmongs, Koreans, Mexicans, Eastern Europeans, Hispanics, Arabs, Afghans, Middle Eastern peoples, and Iranians. From 1981 to the present, research involving diverse populations of immigrants and refugees in a variety of areas has emerged. These studies report that immigrants and refugees still suffer from many problems regarding adjustment, caring, parenting, and accessing social services and health care.

It is critical that nurses recognize that immigration, even in the best situation, is a stressful experience. The major sources of stress are adaptation to cultural and communication (both verbal and non-verbal) differences in the new country and the growing realization that the meanings attached to behaviors, norms, and symbols before

immigration are now different. Other sources of stress are disorientation, loss of friends, and unfamiliar surroundings. Therefore, in the new situation, immigrants need extra time and energy to determine the most appropriate actions when they or their family members become ill. As Lipson and Meleis (1985) have pointed out, "Immigrants often experience a degree of loss of familiar ways, familiar meanings, and particularly, the social network on which they previously depended" (p. 49).

Immigration and Health

Williams and Berry (1991) studied first generation immigrants. They showed that losing one's identity and becoming acculturated is one of the most important stressors in life and that these stressors reduce physical, psychological, and social health. Schumacher and Meleis (1994) stated that immigration is a transition. During this transition, immigrants lose their support networks, possessions, meaningful attachments, and often even their own identity. These losses are frequently associated with conflict, new expectations, stress, and mental and identity issues that pose threats that may compromise immigrants' physical or mental health (May, 1992; Schumacher & Meleis, 1994; Stevens, Hall & Meleis, 1992; Williams & Berry, 1991).

Some immigrants and refugees experience additional stress pertaining to feeling belittled and ignored (Anderson, 1991). Anderson (1991) examined Chinese immigrant women in Canada who were experiencing a chronic illness, diabetes. She asked them what it was like for non-English–speaking women to live with a chronic disease in Canada. Their response to this question was that they felt devalued and that their culture and their beliefs were not considered in their interaction with heath care professionals. Anderson suggested that when health care providers are dealing with immigrant clients, it

is very important to consider the contextual conditions of distress rather than focusing only on micro factors such as diabetes (in this study) or compliance with treatment.

Additional stresses that affect the health status of immigrant women include poverty, marginalization, gender gaps, unemployment, multiple-role burden, social isolation and discrimination, and language barriers (Bagheri, 1992; Beiser, Gill, & Edwards, 1993; Dossa, 1999, 2001, 2002; Morris et al., 1999; Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002; Vissandjee, Carignan, Gravel, & Leduc, 1998).

Many studies have shown that because immigration is considered a stressful life event, it may increase the risk of adverse health outcomes such as hypertension, cancer, and heart disease (Hull, 1979; McKinlay, 1975). Some researchers have found that because immigrants cope with their new environment by changing their habits, physical activities, and lifestyle over time, they become susceptible to some diseases that are not common in their countries (Stephens, Foote, Hendershot, & Schoenborn, 1994). Stephens and colleagues suggested that immigrants had often undergone behavioral changes that put them at risk in their new host country and that the resulting health problems developed because their access to health care services was limited.

Canadian health survey findings show that newly-arrived immigrants to Canada, particularly those from non-European countries, are initially healthier than their Canadian-born counterparts (Chen, Wilkins, & Ng, 1996a, 1996b) because immigrants are selected based on their excellent health status (Citizenship and Immigration Canada, 2000). However, their health status changes over time. Chen et al. (1996a, 1996b) reported that the prevalence of chronic conditions and long-term disabilities among those born in Canada is the same as that of immigrants who have lived in Canada for at least 10

years. They suggested that the long-term stress associated with adjustment, unemployment, and low income, as well as poor working conditions, physical environments, and poor health practices, negatively affect immigrants' health status. These studies are important as they suggest that immigrants, although healthier than their Canadian counterparts of the same age on immigration to Canada, converge toward the norm once settled in Canada and thus become less healthy than would be expected from their health status on arrival.

Efforts to help immigrants address health problems is frequently complicated by different beliefs regarding healthy lifestyles, pregnancy, childbearing, and parenting (Dempsey & Gesse, 1983; Elliott, Berman, & Kim, 2002; Flaskerud, 1990; Kulig, 1995; Lipson, Hosseini, Kabir, Omidian, & Edmonston 1995; Lipson & Miller, 1994; Park & Peterson, 1991). Dempsey and Gesse (1983) studied Haitian pregnant women who had been admitted to hospital to give birth to their children. They found that the meaning and the perception of pregnancy were only in some ways the same as for their American counterparts, but their responses revealed the need for an accurate and specific assessment of each client in order to offer appropriate health care.

Kulig (1995) conducted an ethnographic study of Cambodian refugees in Canada and the United States with a focus on the relationship between resettlement and Cambodian women's roles in childbearing and family planning. She found that before marriage, their knowledge about pregnancy was very limited and teaching about family planning was taboo. This population resisted information related to sexuality. They were not interested in participating in family planning programs before marriage or after marriage.

Korean immigrant women had beliefs, practices, and experiences associated with childbirth that were influenced by their holistic view of health, such as having a healthy lifestyle, proper nourishment, a good environment, lack of stress, good stress management, family harmony, and faith in God. They did not practice preventive tests such as Pap smears or breast self-examinations (Park & Peterson, 1991).

In a study of Afghan women, Lipson et al. (1995) showed that Afghan women did not use preventive care, and they tried to control information regarding sexuality and the sensitive topic of spousal abuse. They knew very little about their bodies and how they worked, and they were hesitant to talk about menstruation or any topic related to women's bodies. Furthermore, parents refused to allow their daughters to take sex education in American high schools. The authors noted that this lack of knowledge may increase the risk of pregnancy and sexually transmitted diseases in young Afghan women.

Compared to Canadian-born women, immigrant women face many additional barriers to maintaining and/or improving their health behaviors. These barriers are related to the transitions associated with immigration, to losses and to socioeconomic factors that are part of Canadian society (Bagheri, 1992; Behjati-Sabet, 1990; Waxler-Morrison et al., 1990, 2005).

Immigration and Access to Health Care Services

Communication

Many of the problems that contribute to additional health challenges for immigrants also reduce their ability to access health care services. The most significant problem is related to communication. Many authors have documented the relationship

between language barriers and decreased access to health care services (Choudhry, Srivastava, & Fitch, 1998; Christensen 2001; Edwards, Ciliska, Halbert, & Pond, 1992; Elliott et al., 2002; Lee, 1994; Lipson, 1992; Pyke, Morris, Rabin, & Sabriye, 2001; Sawyer et al., 1995).

Communication covers all aspects of thoughts, feelings, and the way that people respond to their environment both verbally and non-verbally. Immigrants and refugees have often identified communication barriers as the most problematic issue. When discussing access to health services Toumishey (1995) stated, "communication difficulties are further compounded through a lack of understanding of the meanings of culture specific signs, symbols, gestures, emotional connotations, historical references, traditional responses and pointed silences." (p. 113). Communication is a means of knowing and understanding, and language is one of the most important means of communication.

The use of interpreters and translators to address communication issues may be of benefit, but this is not always the case. Interpreters are used for oral communication and translators for written materials. Christensen (2001) examined the pattern of health-seeking behaviors and factors affecting health care access for Vietnamese, Latin Americans, and Africans in the Greater Vancouver area. She found that the level of satisfaction with health care received was higher in women who had less of a language barrier, were younger, and had a high socioeconomic status. She added that cultural interpretation and translation should be available routinely. Neufeld et al. (2002) suggest that inadequate language proficiency, which requires using family interpreters who lack

complex English vocabulary and medical terminology, impedes the ability of the informal caregiver and family to understand their relative's condition. This situation can limit supports and services available to patients and have negative impacts on caregivers' health.

The Canadian Task Force on Mental Health Affecting Immigrants and Refugees (1988) has shown that immigrants who are proficient in an official Canadian language (English or French) receive more exposure to health promotion than do immigrants with poor knowledge of English or French. Markland and Turnbull (1995), in a study of more than 100 ethnic or cultural groups found that because of the language barrier a basic inequity existed regarding patients' abilities to access cancer information in their own languages. They suggested that Canada's diverse society requires new approaches for preventing cancer, such as redefining problems, restructuring strategies, and having stakeholder groups from different cultures work together to devise methods that target their communities.

Perceived Negative Health Care Provider Attitudes

Perceived negative public attitudes are another factor associated with decreased access to health care services (Pyke, Morris, Rabin, & Sabriye, 2001). Elliott et al. (2002) found that Korean women felt ignored by health care professionals because the health care providers did not answer their questions or explain procedures, surgeries, and illnesses to their satisfaction. They reported that Korean Canadian women would have preferred Korean doctors who share their culture and language.

In 1996 Capital Health Community Care and Public Health established a group—the Dragon Rise Health Team to address negative public attitudes. This program provided

culturally specific community health nursing to facilitate Chinese and Vietnamese families' access to community health services (Morris et al., 1999). In this program, the target population was helped by public health nurses from their countries of origin visiting families during their postpartum period. The participants expressed satisfaction about receiving services that were perceived as culturally appropriate, accessible, and equitable. Their questions and health needs were addressed to an extent not possible through the use of interpreters.

Lack of Information

A third important barrier is lack of information about existing services. Katz and Gagnon (2002) reported that although some immigrant postpartum women and their infants experience problems in the hospital, they are discharged with no follow-up or referral to community resources. These researchers have suggested that there is a need to study the adequacy of health care services delivered to postpartum immigrant women and their newborn infants and to analyze potential differences according to criteria such as immigration status, length of time in Canada, language ability, education, socioeconomic status, and region of birth.

Many studies have shown that immigrant women suffer from mental discomfort and depression but do not ask for help or use the available services due to language barriers, not knowing how to access centers that provide services, or lacking awareness of existing programs (Dossa, 1999; Dossa, 2004a, 2004b). Health care professionals must not assume that because immigrants do not use available services, they are healthy and do not need help. Hyman and Guruge (2002) challenged public health professionals to discern how to help immigrants to maintain and promote their health by using available

public services, such as disease prevention programs or screening programs for cervical or breast cancer.

Health care professionals are in a key position to enhance successful breast-feeding and offer culturally sensitive support, particularly to first-time mothers (Côté et al., 2000). However, Loiselle, Semenic, Côté, Lapointe, and Gendron (2001), in their study about impressions of breast-feeding information and support for first-time mothers within a multiethnic community, found that immigrant mothers had significantly lower prenatal-class attendance and breast-feeding knowledge due to language barriers and less exposure to community services, breast-feeding specialists, and informational materials such as the Internet. As a result, they often relied on incorrect information and beliefs from other informal sources, such as family or community members or feel a conflict between their postpartum health and breast-feeding beliefs and practices.

According to Morris et al. (1999), new immigrants must deal with health care services that "may be quite different from what they experienced before coming to Canada" (p. 28). Health care, like other services, is culturally constructed and is different in each country. People cannot apply the strategies that they used previously in a new country.

Use of Health Care Services by Iranian Immigrants

Only a few studies have been done on the use of health services by Iranian immigrants/ refugees. Although some issues pertained more directly to the culture of the host country, one issue found in all studies, regardless of host country, was the problem of language differences and the barrier this posed for communication. Lipson (1992) studied the health and adjustment of Iranian immigrants in the San Francisco Bay area.

She found that Iranians experience culture shock, problems associated with poor mastery of English, perceived loss of status, and difficulty finding work comparable to what they did in Iran. Regarding health issues and health care services, they experienced difficulty in shopping around to find the best and most well known doctors. They also complained of waiting too long for appointments. Almost all newcomers stated that communication was their major barrier to obtaining good health care services.

An ethnographic study of a day center for Iranian immigrant seniors in Sweden showed that they suffered from isolation. Because they had resettled in a new country late in life, adjustment was particularly difficult. Lack of Swedish language proficiency presented an obstacle to obtaining information about the Swedish government's programs (Emami & Ekman, 1998; Emami, Torres, Lipson, & Ekman, 2000; Emami, Bener, & Ekamn, 2001; Karimi Moghari, 2003).

A comparative study between aged ethnic Iranians and Native Swedes revealed that a lack of language skills and knowledge of the Swedish health care system and social services created some additional problems for Iranians. Although all immigrants enjoy social and health care services similar to those of their Swedish counterparts, because of the language barrier, they could not communicate with others in the society and get information about their new environment. This study showed that they suffered from serious loneliness and feelings of insecurity in the host country and that they had more health problems than their Swedish counterparts (Karimi Moghari, 2003).

Bagheri (1992) studied Iranian immigrants in Toronto. He found that many Iranian immigrants had mental health disorders and suffered from depression and anxiety

but did not ask for help because of language barriers, cultural taboos, and stigma regarding visiting psychiatrists.

Dossa (1999, 2004a, 2004b) studied mental health issues of elderly Iranian immigrants in Vancouver. She found that the mental health of Iranians has a close relationship to their role in their family and their society. In this ethnography, the Iranians felt depressed, not happy or well. Dossa found that they were depressed because they had lost their honour, had barriers to health care services, and were isolated by unemployment and language. Socialization and social activity helped them to overcome isolation, and a result, individuals felt better. Psychiatric services were not sought given the stigma associated with this practice, but somatization of mental discomfort was very high.

Methodological Issues

To obtain the real voice of immigrants, the interviewer not only should be a member of their ethnic group who knows both the language and the culture, and is familiar with the participants' historical, political, and social background, but also needs to know how to interview vulnerable groups on sensitive issues. Although many studies have been done on immigrant populations, there have been some methodological issues. Much research has been done by people who were not from the particular ethnic group under study and who did not have enough knowledge of the researched group's language, culture, or historical, political, and social background.

Few researchers have reported that the interviewer(s) was a member of the ethnic group as well as a member of the research group. Some have mentioned that they hired a person from the ethnic group who was not familiar with research and the academic climate, and some researchers have not even mentioned in published reports who

interviewed the participants. In addition, having an interpreter at an interview session, especially if sensitive topics are discussed, might make the interview atmosphere uncomfortable for vulnerable populations. Interviewees might accept and trust research interviewers from their ethnic group and share their opinions with them, but they might not trust interpreters who are not members of the research group and do not work for academia. This might influence the authenticity of the interview and hide the real voices of linguistically-culturally diverse participants.

Gaps in the Literature

Some researchers have specifically studied Iranians, but their studies have focused on youth, the family, and issues pertaining to elderly immigrants, such as stress, marriage, divorce, culture shock, and communication and language barriers. None of these have specifically examined the process of accessing health care services and the kinds of strategies Iranian immigrants choose to use. While many of the health issues of immigrants are rooted in problems that are not related to health care systems, full access to health care services by immigrants would be expected to help these individuals adapt to some of the stresses associated with life in their host countries

There is much evidence demonstrating that barriers such as those associated with communication, negative public attitude, and lack of information about existing services prevent immigrants from receiving adequate health care (Ballem, 1998; Bender, Clawson, Harlan, & Lopez, 2004; Blackford, Street, & Parson, 1997; Cave, Maharaj, Gibson, & Jackson, 1995; D'Avanzo, 1992; Documet & Sharma, 2004; Searight, 2003; Young, Spitzer, & Pang, 1999). Some immigrants have managed to overcome these barriers, despite stresses associated with immigration. A detailed examination of the

process they used is critical if Canadians are serious about making health care accessible to all. Treating all individuals identically will not guarantee high-quality care for all because equal access will not lead to equitable health outcomes. Nurses' main concerns are individuals' lived experiences, the meaning derived from these experiences, and how these experiences affect their health and responses to illness. This research will help nurses to understand the ongoing process of immigrants' health care seeking strategies. Such knowledge will facilitate the development of more appropriate health care services as well as foster greater health professional knowledge about challenges faced by newcomers to Canada. Knowing how immigrants and refugees navigate health care services could help health care providers find ways to facilitate this process more easily and quickly.

CHAPTER III: THE RESEARCH METHOD

Generally speaking, qualitative research is called interpretive research, in that its methods rely on thick descriptions of the particular social context being studied. Qualitative studies describe or answer questions about particular occurrences or contexts and the perspectives of a participant group toward events, beliefs, or practices about which little is known (Denzin & Lincoln, 1994).

An interpretive perspective allows researchers to understand the meanings and actions of individual actors by focusing on the communication acts and processes that give rise to human meaning construction (Berger & Luckman, 1967; Creswell, 1998; McCracken, 1988). According to Baxter and Babbie (2004), interpretive researchers claim that "human action is purposive; it is action intended to accomplish some purpose" (p. 15). An interpretive perspective allows researchers to give a voice to their participants through the use of evocative participant data.

Qualitative research methods focus on meaning and understanding in context (Denzin & Lincoln, 1994, 2000), can be used to explain complex concepts, and provide a better understanding of the nature and dimensions of the subjective experiences. In qualitative research,

- data are descriptive, and data sources are real-world situations;
- the researcher emphasizes a holistic approach;
- data are analyzed inductively; and
- the researcher describes the meaning of findings from participants' perspectives (Parse, 2001).

Strauss and Corbin (1990) stated, "Qualitative methods can give the intricate details of phenomena that are difficult to convey with quantitative methods" (p. 19). Each qualitative research method has a particular philosophical underpinning that is important in answering research question(s) correctly. My choice of a research method for this study relates to the nature of the research question being asked. Grounded theory's structure of analysis is aimed at identifying building blocks that might lead to a holistic theory. The central question grounded theory attempts to answer is "What is happening here?" (Gubrium & Holstein, 1997, p. 675). The question is phrased slightly differently in phenomenology. Phenomenology asks, "What is the essence of the lived experience as described by those having the experience?" Grounded theory, like phenomenology, relies on first-hand experience with the phenomenon in question. In grounded theory, the researcher adapts interview questions based on what he or she needs to learn and/or verify at any given point in the research process. Consequently, the researcher talks with the interviewees as necessary following the initial interviews.

Grounded Theory

Grounded theories provide new ways of thinking about and looking at the world around us (Botha, 1989). The grounded theorist seeks to interpret data to create a theory (Charmaz, 1995b, 2000, 2006). Grounded theory aims to produce a mid-range theory – that is, one preceding a broader and perhaps more significant observation. A mid-range theory can be understood as a step taken to move a concept into a realm that reveals the notion as part of a greater whole. In other words, locating a mid-range theory can lead to a new robust one. Grounded theory focuses on the process of generating theory, emphasizing steps and procedures for connecting induction and deduction through

constant comparison (Patton, 2002). Patton noted that grounded theory is a method that takes the researcher into and close to the real world, so that the results and findings are grounded in the empirical world.

Strauss (1987) stated that grounded theory is a method that outlines a strategy for handling data to generate a theory that captures the complexity of reality and makes convincing sense of it through the discovery of concepts, the identification of core processes, and the development of substantive theory related to such processes. Grounded theory, a theory-generating method, employs a number of interactive, concurrent steps of data gathering, inductive reasoning, hypothesis formation, further purposeful data gathering, and logical deductive reasoning to generate explanations of complex behavior (Glaser & Strauss, 1967; Stern, 1980; Strauss & Corbin, 1990, 1998; Streubert & Carpenter, 1999).

Through process analysis, a grounded theorist uncovers basic social/ interactional processes to account for behavior. By employing grounded theory, a researcher tries to understand the meaning of concepts, events, and situations from the perspective of the research participant. He or she believes that reality is dynamic, not static, a process rather than an outcome. Grounded theory focuses on what is happening with the individual, and between groups of individuals, with respect to a particular context. Strauss and Corbin (1998) emphasized the natural fit between qualitative research and discovering the nature of a person's experiences. They added that qualitative research designs using grounded theory offer the opportunity to develop concepts and linkages that can explain complex phenomena.

Grounded theory originated in pragmatism and is rooted in sociology (Creswell, 1998; Glaser, 1998; Straus & Corbin, 1990, 1994, 1998; Streubert & Carpenter, 1999). Grounded theory applies both an inductive approach and a process of data analysis through constant comparison between segments of the data, which arises from a philosophy based on the symbolic interactionist school of social psychology.

Symbolic Interactionism

Symbolic interactionism was introduced by Thomas and Charles Cooley in the 1920s; later, during the 1960s, philosopher Herbert Mead defined the essential meaning of self and its relationship with and within society (Annells, 1996). Later, Blumer (1969) extended the notion of symbolic interactionism by centralizing Mead's view of the self and looking at the self as a uniquely human attribute constructed through social interaction. The theory of symbolic interactionism focuses on and provides an explanation of self and society in interaction in particular social contexts.

The ontological roots of the grounded theory method go back to Mead (1962) and Blumer (1969). Both believed that although the social and natural worlds consist of different realities, which can be known and evaluated using critical realism, both forms of reality are probabilistic and apprehensible (Annells, 1996). Symbolic interactionism is concerned with understanding the meaning of events for people in everyday situations and with understanding the symbols they use to convey this meaning (Baker, Wuest, & Stern, 1992). According to Blumer, symbolic interaction is a lens for understanding human behavior and is based on three premises: (1) Human beings act toward things on the basis of the meanings that the things have for them. (2) Meanings are a product of social intersection in human society. (3) Meanings are modified and managed through an

individual interpretation process of signs that each person encounters.

Symbolic interactionism is both a theory about and an approach to determining human behavior (Annells, 1996). Symbolic interactionism stresses human behavior development through interaction with others by a continuous process of negotiation and renegotiation. Individuals actively create meaning and reality constructs by interacting with the symbols around them (Morse & Field, 1995).

Because individuals, their society, and their interactions with society are linked, individuals cannot be understood outside the context in which they live. Through the lifetime process of socialization, individuals learn how to participate in society by learning the norms of the cultures in which they live. According to symbolic interactionism, socialization is an active, ongoing process of interaction between individuals and their societies. Researchers study a cultural or social group in their own language and through their own lens and generate a theory grounded in the data to explain identified relationships, which leads to theory development (Morse & Field, 1995).

Epistemological Assumptions

Like phenomenology, grounded theory depends on methods that take the researcher into the real world, so that the results and findings are grounded in the empirical world (Patton, 2002). That is, the roots of the research are in everyday experience rather than in hypotheses and theories. The goal of this approach is to keep the research on the ground, so to speak, and produce a theory that is relevant, applicable, and significant for understanding the world around us.

To conduct grounded theory research, it is vital to know the epistemological assumptions underpinning it, because the analysis can be enriched by this knowledge (Annells, 1996). According to Glaser and Strauss (1967), research should be conducted in the real world based on objectivist epistemological insight about the nature of and the relationship between what can be done and the knower. Therefore, a classical grounded theorist looks for a "real" reality. Glaser (1992) stated that the focus of classic grounded theory is on "concepts of reality" (p. 14) and seeking "for what is, not what might be" (p. 67), based on "true meaning" (p. 55), and valuing the emic viewpoint.

Later, a method presented by Strauss and Corbin (1994) revealed a shift from objectivist toward a subjectivist and transitional epistemology. Strauss and Corbin stated that the researcher should be actively involved with the method, not separate from it (Annells, 1996) and took a different position from that of Glaser with regard to the epistemology in grounded theory (Strauss & Corbin, 1994). They pointed out that analysis consists of interpretations based on multiple perspectives, which evolve to create knowledge (Strauss & Corbin, 1990, 1998), and asserted that although reality cannot be known fully, it can be interpreted. Therefore, Strauss and Corbin's epistemologic view is relativistic. They believe that reality exists as multiple mental constructions and that there are no differences between social- and natural-world realities (Annells, 1996, Charmaz, 1995b, 2000; Strauss & Corbin, 1990, 1994, 1998).

Later, Guba and Lincoln (1994) and Charmaz (1995a, 2000, 2006) stated that although Strauss and Corbin, by taking interpretation into account and giving voice to participants, have moved from positivism into the postpositivist school of thought, they still perpetuate objectivism by seeking an external reality and maintaining a detached

position from the participants.

Constructivist Grounded Theory

In the most general terms, constructivism refers to the theory that knowledge is not something we *acquire* but something we *produce.* In other words, "constructivists hold that the substance of an area of inquiry is not there to be discovered but is invented or constructed" (Mautner, 1999, p. 111). The notion of constructivism includes many branches, among them ethical constructivism and social constructionism. Ethical constructivism is the notion that moral facts and truths either are constituted by or dependent on our moral beliefs, reactions, or attitudes. In this view, "given equally coherent epistemic conditions, the truth or lack of it in a particular moral belief is predicated on a moral system or code" (Audi, 1999, p. 283).

Social constructivism holds that knowledge is the product of our social practices and institutions, or of the interactions and negotiations between social groups. In the mildest form of this view, social factors shape interpretations of the world. Stronger versions maintain that the world, or some significant portion of it, somehow is constituted by theories, practices, and institutions. Audi (1999) pointed out that social constructivism has roots in Kant's (1964) idealism,

> which claims that we cannot know things in themselves and that knowledge of the world is possible only by imposing pre-given categories of thought on otherwise inchoate experience. But where Kant believed that the categories are given a priori, contemporary constructivists believe the relevant concepts and associated practices vary from one group or historical period to another. Since there are no independent standards for

> evaluating conceptual schemes, social constructivism leads naturally to relativism. (p. 855)

According to Baxter and Babbie (2004), positivist researchers can muddle or hide the voices of participants through the use of variables and objective measures. Later, Charmaz (1983, 1990, 1995a, 1995b, 2000, 2006) introduced constructivist grounded theory, which transformed the traditional research method developed by Glaser and Strauss (1967) from a positivist/postpositivist mode of inquiry to a more interpretive, postmodern approach. As explained by Charmaz (2002),

> the constructivist approach to grounded theory places priority on the phenomena of study and sees both data and analysis as created from the shared experiences of researcher and participants and the researcher's relationships with participants. In this view, any method is always a means rather than an end in itself. In this view, data analysis is perceived as a construction that not only locates the data in time, place, culture, and context, but also reflects the researcher's thinking. (p. 677)

In contrast, objectivist grounded theory assumes that data represent objective facts about a knowable world. This position holds that the data already exist in the world and that the researcher's task is to find them. In this view, meaning is in the data and the grounded theorist discovers it. This perspective assumes an external reality awaiting discovery and an unbiased observer who records facts about it.

The aim in constructivist inquiry is to understand, reconstruct (Guba & Lincoln, 1994), and provide a way of reclaiming grounded theory tools from "their positivist underpinnings to form a revised, more open-ended practice of grounded theory that

stresses its emergent, constructivist elements" and "flexible, heuristic strategies" instead of "formulaic procedures" (Charmaz, 2000, p. 510), which enable researchers to seek meaning instead of "truth." Charmaz stated,

> Constructivist grounded theory celebrates firsthand knowledge of empirical worlds, takes a middle ground between postmodernism and positivism, and offers accessible methods for taking qualitative research into the 21st century. Constructivism assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understanding of subjects' meanings. (p. 510)

She added, "The constructivist view assumes an obdurate, yet ever-changing world but recognizes diverse local worlds and multiple realities, and addresses how people's actions affect their local and larger world" (Charmaz, 2006, p. 132). Charmaz (2000) agreed with Maines (1993) and Bond (1990) that data are narrative constructions and reconstructions of experience, not the original experiences themselves. She considers both emic and etic points of view and their interpretation of reality, and differentiates between what is "real" and what is "true," pointing out,

> The constructivist approach does not seek truth – single, universal, and lasting. Still, it remains realist because it addresses human *realities* and assumes the existence of real worlds. However, neither human realities nor real worlds are unidimensional. We act within and upon our realities and worlds and this develops dialectical relations among what we do, think, and feel. The constructivist approach assumes that what we take as real, as

objective knowledge and truth, is based upon our perspective. (p. 523)

Charmaz (2006) claimed that researchers should try to find reality based on participants and also foster their own consciousness about how, when, and why they portray these definitions as real. Then, the product of research is an interpretation of a shared or individual reality among multiple interpretations. There is no single, "true," objective reality out there to be discovered. Rather, realities are created and, therefore, "dependent for their form and content on the individual persons or groups holding the constructions" (Guba & Lincoln, 1994, pp. 110-111). There is an ongoing change in "the viewed" and "viewer." Knowledge is reciprocally created or constructed between the viewed and the viewer, and what can be known cannot be viewed apart from the knower—the researcher—or the viewer—the participant (Charmaz, 2000)—and turns out to be "an image of *a* reality, not *the* reality" (p. 523).

Constructivist researchers should listen to participants' stories with openness to feeling and experience, and the researcher should be someone to whom participants can express their private thoughts and feelings. A constructivist grounded theory approach contains the understanding that data do not provide a window on realty. Rather, the viewer creates the data through interaction with the viewed in data analysis. Through constructivist grounded theory, "the discovered reality arises from the interactive process and its temporal, cultural, and structural contexts" (Charmaz, 2000, p. 524). In the constructivist approach, categories, concepts, and the theoretical level of analysis emerge from the researcher's interactions within the field and the data questioning. By sharing our participants' world, we will be able to conjure up an image of participants' constructions and of our own (Charmaz, 2000).

Summary

In conclusion, if the chosen philosophical perspective is classical grounded theory based ontologically on critical realism and accepting of a modified objectivist epistemology, the paradigm of inquiry is congruent with Guba and Lincoln's postpositivist belief system. Alternatively, if the ontology of choice is relativist and the epistemology is subjectivist, as in constructivist grounded theory, the paradigm of inquiry is congruent with Guba and Lincoln's postmodern paradigm of inquiry (Annells, 1996).

It is important to note here that grounded theory studies are not descriptive research, as the stated purpose of a grounded theory study, its sampling techniques, and data analysis strategies are different from those of descriptive studies. Descriptive studies answer the question "What is going on here?" whereas in grounded theory studies, description is not the end but a means to an end, in which the question "What is going on and how?" is answered through explanations or specific theories regarding social phenomena (Becker, 1993).

According to Strauss and Corbin (1990), in grounded theory, data gathering, data collection, data analysis, and theory are intertwined throughout the process of developing a theory that is grounded in the data. In grounded theory, theory generation is the product of theoretical sampling, the use of a coding paradigm, and constant comparisons on the part of the researcher (Strauss, 1987). Charmaz (2002) provided that all variations of grounded theory include six strategies:

> (a) simultaneous data collection and analysis; (b) pursuit of emergent themes through early data analysis; (c) discovery of basic social processes within the data; (d) inductive construction of abstract categories that

> explain and synthesize these processes; (e) sampling to refine the categories through comparative processes; and (f) integration of categories into a theoretical framework that specifies causes, conditions, and consequences of the studied processes. (p. 677)

Method for this Study

The approach Charmaz (2002; 2006) takes to grounded theory, and the one most appropriate for my research question, is a symbolic interactionist theoretical perspective with constructivist methods. Both symbolic interactionism and constructivism emphasize the study of how actions and meaning are constructed. In this approach, the researcher aims to learn the implicit meanings that relevant experiences have for study participants and build a conceptual analysis of them. Charmaz's approach to grounded theory hinges on three assumptions: (a) multiple realities exist; (b) data reflect the researcher's and the research participants' mutual constructions; and (c) the researcher, however incompletely, enters and is affected by participants' worlds. This approach explicitly provides an *interpretive* portrayal of the studied world, not an exact picture of it.

The Relevance of Grounded Theory for this Study

Qualitative methods are appropriate for those questions that primarily require inductive analysis, through description and interpretation of a variety of human experiences. Grounded theory is the method of choice for this study for several reasons. Schreiber (2001) found grounded theory useful when researchers want to learn "how people manage their lives in the context of existing or potential health challenges and as such, is admirably suited to nursing inquiry" (p. 57).

Grounded theory is an appropriate and useful method when there is limited information on a topic or on particular aspects of a topic (Strauss & Corbin, 1990) that has not been fully identified. In this regard, few researchers have investigated how immigrants navigate health care services in their host countries, and none have focused on Iranian immigrants in Canada.

The central research question of this study addresses the experiences and perceptions of Iranian immigrants in interaction with a particular environment, with a focus on process, subjectivity, context, and language. As Morse (2001) said, "Grounded theory is less concerned with particular context, cultural perspectives, and world views than ethnography. It is more concerned with how participants create and respond to experiences rather than, as with ethnography, what they think or how they perceive their world" (p. 12).

Therefore, grounded theory studies can be carried out in a particular culture with a focus on behavioral concepts as a process. This is possible because participants tell their stories of events from beginning to end rather than focusing on culture (Morse, 2001). Schreiber (2001) said that when we want to learn how people manage their lives in existing or potential health challenges, grounded theory is the approach best suited to nursing inquiry. She added, "What is key in this process is learning the ways that people understand and deal with what has happened to them through time and in changing circumstances" (p. 57).

Choice of Language

After addressing the appropriate method for this study, the next issue relates to the language of inquiry. Language, behavior, lifestyle, health and healing beliefs, history, and

religions are culturally constructed and influenced by cultural beliefs. They are dynamic and subject to change over time. Language shows the representation of social life within culture and illuminates the boundaries and perspectives of a cultural system (Atkinson, 1992). The system of language and its grammar, structures, and style are different in each country.

Moreover, besides differences in grammar, structure, and style, some concepts or words do not have equivalent translations in other languages. Therefore, mere translation is not helpful. For instance, some Farsi (Persian) words have no equivalent in English, and vice versa. To clarify meaning, we need to interpret, define, or exemplify these words. An example is the Farsi word *narahaty*, which is widely used "to express a wide range of undifferentiated, unpleasant emotional or physical feelings, such as feeling depressed, uneasy, nervous, disappointed, or not fully well" (Purnell & Paulanka, 1998, p. 344). To understand and capture the meaning of the word accurately, the researcher must have mastered Farsi; otherwise, he or she would end up with an incorrect interpretation. It is imperative to understand that concepts are culturally embedded and acquire their specific explanatory meanings through verbal networks; each culture has its own verbal interpretation of reality (Barnes, 1996).

In addition, words cannot cover all emotional expression. Many emotional expressions are conveyed nonverbally. Nonverbal communication, such as emotional expression, body gestures, and physical distance, conveys many messages during interviews (Barnes, 1996). For an adequate analysis of culture, researchers need to know how to record verbal and nonverbal communications by addressing the issue in their data collection (Barnes, 1996). Barnes pointed out that "every culture attaches meaning to the

context of a conversation or interview" (p. 433). Cultural habits, beliefs, and learned styles of interaction shape respondents' responses in naturalistic settings and interviews (Lipson, 1999).

Although my study of Iranian immigrants is not about culture, culture and language play important roles in the conduct of this study and its accurate interpretation. Accurate interpretation, sharing meaning and constructing a shared meaning between the researcher and participants, is pivotal to this study. For this reason I told participants the interviews could be conducted in Persian (Farsi) or English, depending on the preference of the participants. All participants spoke in Persian although some inserted English words into their speech.

According to Charmaz (2000), constructivist grounded theory seeks meanings – both those of the participants and those of the researchers. Constructivist grounded theory moves into the realm of interpretative social science based on Blumer's (1969) emphasis on meaning and disbelief in a unidimensional external reality. To do so, researchers should go beyond the surface, or presumed meanings, to look for acts, facts, views, and values, as well as beliefs, ideologies, situations, and structures. Charmaz (2000) stated, "By studying tacit meanings, we clarify, rather than challenge, respondents' views about reality" (p. 525). My knowledge of both Farsi (Persian) and English allowed me to do this.

Overview of Research

Health care researchers currently use various approaches in their application of grounded theory (Lowenberg, 1993) because of its emphasis on theory development (Strauss & Corbin, 1994) and middle-range theory. With respect to multiple realities

within cultural pluralism and diversity in the world generally, and in the health care system specifically, grounded theory through a cultural lens is one of the most often suggested qualitative research traditions for interpreting clients' perspectives of their experiences with health care services (Morse, 2001; Schreiber, 2001).

By employing constructivist grounded theory, I was able to develop a theory that health care workers can apply in similar situations involving immigrants and refugees to understand their ways of seeking health care services in their host countries and then use this knowledge to help them to understand how to access services in Canada and, consequently, to inform and enhance the health care providers themselves.

The constructivist grounded theory approach provided a theoretical rationale for application of grounded theory to the research problem of how Iranian immigrants/refugees access Canadian health care services. In this study, I generated a model from the data of the research participants about how Iranian immigrants/refugees accessed Canadian health care services and became self-sufficient.

Ethical Considerations

The Health Researcher Ethics Board (HREB- Panel B) of the University of Alberta provided guidance related to ethical issues. Upon approval by my thesis committee, the proposal was submitted to HREB- Panel B for approval. The information sheet and consent form are included in Appendices A and B.

Research Question

The research question in this study was "What are the processes by which Iranian immigrants learn to access health care services in Canada?"

Sample Selection

Morse (1991) believes that a researcher must be able to choose good informants who have appropriate experiences and knowledge and are able to reflect those experiences and knowledge in an articulate way. Individuals who come to Canada from Iran come primarily as political refugees, to reunite with family, or as independent immigrants. My focus in this study was on two groups of Iranian immigrants, those who came independently (not students or those who were sponsored) and those who came to Canada as refugees under the terms of the Geneva Convention and were recognized as such by the Canadian government. Additional eligibility criteria included immigrated to Canada within the past 15 years, currently living in Edmonton, and 18 years or older at the time of immigration (See Appendix C). Seventeen participants were recruited (11 women and 6 men) (See Appendix D.2) until all data categories were saturated and no new information was obtained. Because my goal was to understand the process by which Iranian immigrants access the heath care system in Canada, I began with a purposeful sampling approach and interviewed individuals who immigrated to Canada at least five years ago (Morse & Field, 1995). As data analysis progressed, additional interviews with more recent immigrants were conducted to strengthen the emerging theory.

Data Collection Procedures

There are three active Iranian communities in Edmonton that have social activities and gatherings. I contacted the executive secretary of each community and immigrant center in Edmonton to inform Iranians of the study by posting advertisements concerning the ongoing research under the title, "Iranian immigrants' access to the Canadian health care services" (See Appendix C). In this advertisement, group members were invited to

contact me by telephone if they wished to participate. Following informants' calls, I explained the study and answered any questions. Those willing to take part in this study signed a consent form and were given an information letter to keep (See Appendix B).

Gaining Entry

In doing this research and gathering data, I faced some challenges such as recruiting key informants, building and maintaining trust and reflexivity, and situating myself between being an insider and an outsider.

Recruiting key informants was one of my challenges. Iranian immigrants and refugees leave Iran for different reasons. Although individuals whose ideologies are close get together and make small committees and groups, these small groups do not unite to make a community. Iranian immigrants in Canada are not exceptional. There are a few Iranian societies in Edmonton but not a community yet. It was vital for me to be able to talk to and communicate with Iranians from most of the different groups. To recruit participants from all groups, building and maintaining a trustworthy relationship was critical.

To capture the essence of a phenomenon, participants and I needed to build a trusting relationship. As we know, when a person trusts another person to share his/her ideas, thoughts, feelings, or information, it is like walking a tightrope over a place filled with crocodiles at one end and alligators at the other (Weber & Carter, 2003) without a safety net. It does not matter where he or she lands; the end result is to be in danger. Since I was dealing with immigrants and refugees, building and maintaining trust was one of my challenges. Immigrants/refugees often do not trust people outside their family to the point where they share with them all of their information, issues, experiences, and

terrible life events, out of fear of losing face in front of them or society, being stigmatized or stereotyped, losing their privacy, and/or being deported to their homeland.

The meaning of trust in my country, Iran, is different from that in developed countries. People's beliefs have been shaped by their past and recent experiences and histories. Knowing the history of participants' countries, their culture, and their language can help to overcome with this issue.

Although as an Iranian, I knew the history, culture, and official language of Iran, I realized that they were not enough to build a trusting relationship. Since Iranians have different political, religious, social, and economical backgrounds, any wrong move could put the trusting relationship in danger. I needed time to get close to them, learn about their fears, and be seen as the same as they are. Over time, I had the opportunity to prove my trustworthiness. I knew why it was hard for them to trust me. I was born and raised in Iran. I witnessed the backlash in Iran against different ideas, thoughts, and religions. They were reported to intelligence services by their friends and neighbors. Many of them were killed without having the right to hire lawyers or even have a court hearing.

Building and maintaining a trustworthy relationship was a process in itself. This situation helped me to be sensitive about participants and to look at them as unique individuals. Trust starts through relationships; therefore, I had to start a kind of relationship with them. The question was, with which group? How far I could go? How could it be possible to reassure them that I was not related to any political parties in Iran or in Canada? How could it be possible to make them understand that all of the information was just for sake of Canadian health care service to provide better services to them and had nothing to do with the Iranian government? Interpersonal trust emerged

through visiting and interacting with them. Still, I was not sure how much they would say.

Even when they accepted to take part in my study, other issues came up. Signing consent forms and recording interviews brought another suspicion into play. Confidentiality is an important issue for all Iranians. They have been betrayed by trusting their relatives, friends, and neighbors. It is a strong belief in Iran that "Don't trust anybody until you see the evidence". The history of Iran has shown them that every time Iranians have trusted a person, institution, organization, or government, they have received punishment and backlashes, they have lost their lives, or their loved ones have been killed or persecuted.

By being with them and not participating in certain activities, I kept myself close to them; they understood that I was not associated with any particular political or religious parties. Although I did not participate in any social or cultural activities, I took part in some social humanitarian activities to show my respect for freedom of speech/expression and human rights. After building trust I had to maintain trust which was hard work by itself. A very first thing that I needed was to convince them that they would not be in danger by signing the consent form. I assured them that I was recording interviews for the sake of this research and their name would be removed from the original tapes, and nobody is allowed to hear their voice. Well, it was not enough, even though they signed consent forms and agreed to take part in interviews, I had to be sure that they were going to talk and share openly.

The next issue related to trust was responding to disclosure while I was interviewing them. In interview sessions, the hardest part for me was how to handle, deal,

and respond to disclosure. It was risky for some of them to disclose information about themselves that violated normative standards of the community, and that was why it became crucially important in constructing trust. In self-disclosure, confidentiality has a vital role, because sharing certain information about oneself could result in stigmatization and stereotyping. If people think that by disclosing themselves to others, they will be stereotyped or stigmatized, they come to the conclusion to not share their information, and this will result in unmet trust. They engage in self-censure rather than self-disclosure. To continue I should be nonjudgmental. Nonjudgmental approach helped me to maintain a trustworthy relationship with participants.

Since in qualitative approaches, the focus is to understand meaning through the voice of the participants, researchers must be aware of the fact that language is embodied in cultural and moral beliefs. They also must have a good insight into the cultural construction of life experiences because cultural beliefs and values form powerful experiences and shape how people make sense of and respond to events. Strictly speaking, culture and language are interwoven and to understand the participants' experience, the researcher should be a member of that cultural group.

In addition, it helps participants feel comfortable to describe and share their experiences and reveal every element of them. Clearly, if researchers do not know minorities' particular cultures and languages, they cannot build strong and trustworthy relationships through communication. It is important to show informants that "I am like you", otherwise informants will keep a distance between themselves and researchers. Meleis (1991) pointed out that whatever research design is chosen to study immigrants, it must be mediated through members from the cultural group, which involves collaborating with

others from that culture and immersing oneself in that culture. It was really important for me to keep a balance between objectivity and sensitivity. Being an insider helped me to understand the situation. I was an outsider to this research because I was working in hospital and I knew how the system works in Iran and in Canada.

Data Collection

The mode of data gathering was interview. Being an immigrant and having experience of health care systems in both Iran and Canada was a privilege, as I could understand the participants' language, feelings, culture, and historical background. It also facilitated the development of trust during the interview process. I scheduled interviews at the convenience of the participants. The interviewees chose the place and the time of the interview. There are definite advantages of being an insider. I was aware that my own status with respect to education, immigration, class, religious affiliation, and gender could have an impact on both recruitment and information that participants may share.

Before starting the interview, I asked participants to fill out a demographic data sheet that included information on their place and date of birth, sex, year of immigration, immigration status, marital status, number of children, education, and present occupation (See Appendices D.1 & D.2). Because Iranians are very reluctant to discuss their reason for leaving Iran, whether as immigrants or as refugees (Behjati-Sabet, 1990, Behjat-Sabet & Chambers, 2005), I recorded participants' status as "refugee" if they provided this information, but did not specifically ask questions regarding their status. Because Iranians are reluctant to talk about their economic status and consider this a very personal matter, I did not ask about it.

Informants were told that multiple tape-recorded interviews (1 to 3) might be conducted as necessary to identify and clarify a theory that explains the basic patterns that characterize learning to access health care services (Charmaz, 2000). Interviews were conducted, tape-recorded, transcribed, and analyzed in Persian (Farsi), as all participants preferred speaking Persian.

The interview started with a very broad opening statement, such as "Tell me about your experiences after coming to Canada." I initially conducted open-ended, interactive interviews to examine the process of immigrants seeking health care in Canada. Interviews became more structured as the study progressed. The purpose of this strategy was to prevent me from guiding participants. As Morse and Field (1995) advised, I used phrases such as "tell me," "tell me more," and "I want to hear your whole story" to encourage the participants to tell their stories in their words and at their own pace. For more clarification, I asked "What makes you say that?" Following the informants' responses, I asked more questions based on the data obtained from the first question (See Appendix E for examples of interview questions). In the second and third interviews, I told participants what I had learned from the first interview to gauge how well I had captured their stories. I also shared concepts that emerged from my data analysis and invited their comments. This is called a member check (Schwandt, 2001). Recruitment began with individuals who had been in Canada for between 5 and 15 years. As the process became clear, I recruited more recent immigrants to explore the early stages of the process in more detail.

I anticipated that an interview would take approximately 1 to 1½ hours, but it took longer—up to 3 hours—for some participants, so they could continue to record

information they felt was vital to understanding the process of their journey toward becoming integrated and self-sufficient. The majority of participants appeared open and comfortable throughout the interview. As Spradley (1979) suggested, I kept a journal and recorded my personal feelings, ideas, problems, or fears as a way of keeping track of my progress as a research instrument.

I transcribed all interviews. I proofread each transcript carefully by listening to the taped interview and considering both spoken and unspoken expressions, such as silence, laughing, crying, or voice changes marked in the written transcripts for accuracy of transcription. The transcripts ranged from 30 to 82 pages double-spaced. Interviews were translated into English with the assistance of an Iranian who was born and raised in Iran and lived in the United States for many years. He was fluent in both Persian and English and was knowledgeable about Iranian culture and the historical and political background of Iran. To check the accuracy of the translation and to maintain the authenticity of words, I employed back-translation procedures for 4 interviews.

For back-translation, the translated versions were sent to another Iranian who was fluent in both English and Persian and was living in the United States (the same criteria) to translate the interviews into Persian. I compared these translations for accuracy. Back-translated interviews to Persian (Farsi) were the same as the English translations, with some adjustment of words and idioms. Because three participants were fluent in both Persian and English, I asked them to read their translated interviews and confirm their accuracy. All of these participants stated that the translations matched what they had said in Persian (Farsi). The narrative is presented here in English. To ensure coding accuracy, I compared two translated interviews that my supervisor and I coded separately.

During the data collection, I made notes about my thoughts, feelings, and observations related to each interview to be aware of my role in constructing data. Charmaz (2000) believes that "data remain constructions" (p. 514), that data do not exist by themselves. The researcher and the participants create data through construction and co-construction of data. My reflective notes helped me to understand the participants' experiences. As Charmaz (2000) has stated, "what a viewer sees shapes what he or she will define, measure, and analyze" (p. 424).

Data collection took about a year (2004-2005). At the time, I was familiar with some literature and aware of gaps in it, but did not use this understanding to predetermine what would be discovered in the research. In qualitative studies, researchers rely on themselves as the main instrument of data collection (subjectivity, intersubjectivity), analyze data through interpretative lenses, and employ expressive language and voice in descriptions and explanations.

Data Analysis

The main goal of grounded theory is the generation of a theory, or set of interrelated propositions, that are grounded in the data. Data collection, analysis, and interpretation are simultaneously conceptually driven. In grounded theory, coding (open and selective), theoretical memoing, and constant comparison are fundamental analytic methods. Open and initial coding helps the researcher to move from the data to theory (Charmaz, 1983, 2006).

Data were managed using existing Persian software (Farsi Negar and Zar Negar). This facilitated a thorough and systematic approach to the constant comparison required in grounded theory. Grounded theory involves three modes of coding, which are not to be

considered as distinct stages (Strauss, 1987). Charmaz (2006) considers coding a process of sorting or categorizing data. The first level is open coding. Open coding generates categories through sociological, or in vivo, codes (words used by participants) derived from analysis of the text (Strauss, 1987).

In the second level of coding, the researcher examines and collapses codes into categories, or higher level concepts (Schreiber, 2001). According to Glaser (1978), the goal in the second level of coding is the generation of "an emergent set of categories and their properties which fit the data, work, and are relevant for integrating into a theory" (p. 56). At this level, the researcher constantly compares the first level of coding against existing and incoming data and identifies categories. To determinate similarities and differences, the researcher compares incidents to incidents and incidents to concepts (Schreiber, 2001). The second level of coding roots out the causes, effects, conditions, actions, and strategies around a phenomenon and generates a coding paradigm that specifies the conditions, context, consequence, and interactions of the specific phenomenon (Strauss, 1987). The construction of properties and dimensions of open codes facilitates the social construction of reality.

The goal in the third level of coding is to hypothesize relationships among the lower level codes (Schreiber, 2001). I coded without the use of a computer. As Strauss (1987) and Charmaz (2006) suggested, I employed memos, graphic representations, and diagrams to assist with coding. I began my analysis of the interviews during each interview and through the transcription of each interview by making analytical memos related to the formulation of theory (Charmaz, 2006). The transcription process itself

provided the opportunity to begin coding, as I could make memos when I took breaks from transcribing.

To begin the analysis, I applied a two-step process for coding data. The first, called initial coding, is a line-by-line coding. In this part, I considered each line of a story or statement told by an interviewee and reduced it to key words and phrases that indicated what was happening in the story. I did this by creating two columns – one showing the story as told and the other showing my coding. The second step in this layer is called focused, or selective, coding, which is a process of reduction. Again, I looked at the entire story as told but coded the content only where there were significant shifts or revelations in the story.

The first level of coding forces the researcher to begin to make analytic decisions about the data. The second forced me to identify the codes appearing the most frequently and use them to sort, synthesize, and conceptualize large amounts of data. Coding, then, helped me capture categories that simultaneously described and dissected the data. As Charmaz (2002) described,

> In essence, coding is a form of shorthand that distills events and meanings without losing their essential properties. During the coding process, the researcher (a) studies the data before consulting the scholarly literature, (b) engages in line-by- line coding, (c) uses active terms to define what is happening in the data, and (d) follows leads in the initial coding through further data gathering. (p. 684)

In this respect, coding in grounded theory is aligned with reduction in phenomenological research practices. I addressed theoretical sensitivity by constantly

asking questions of the data—"What are these data telling us?"—and letting the data reveal themselves (Glaser, 1978). I coded the data line by line, sentence by sentence, and paragraph by paragraph by asking questions of the data, followed by "What category, property, or incident is emerging?" In analyzing narrative data, data derived from unstructured interviews, I developed commonsense understandings of the events and experiences recounted by informants, then moved on to more abstract conceptualizations of the materials by uncovering and making explicit strong relationships between key concepts.

Finally, I asked, "What is really happening in the data? "What are the common happenings among Iranian immigrants accessing health care services in their host country?" To check and fill out emerging data, I created particular interviews or code categories (Charmaz, 1983). According to Charmaz (2000), the aim of grounded theory is to refine, elaborate, and exhaust conceptual categories rather than increase the original sample size. Therefore, I selected a limited number of the most relevant codes (Charmaz, 1995b), and if some data did not fit with the selected codes, I returned to the initial coding to find out how these new codes fitted into the emerging theory.

The second level of analyzing in grounded theory is memo writing. Akin to my process notes, I defined the properties of each category identified in the coding, specifying conditions under which each developed, was maintained, and changed. The memos also noted the consequences of each category and its relationships with other categories. In the end, I took the categories identified and drew examples from these memos to illustrate each category. The aim of this standard of rigor was to connect my

original interpretations with the data and help me avoid forcing data into existing theories.

Charmaz (2002) wrote that memo writing helps grounded theorists to (1) stop and think about the data; (2) spark ideas to check out in further interviews; (3) discover gaps in earlier interviews; (4) treat qualitative codes as categories to analyze; (5) clarify categories—define them, state their properties, and delineate their conditions, consequences, and connections with other categories; and (6) make explicit comparisons—data with data, category with category, concept with concept (p. 687). Memos in grounded theory read sometimes like stream-of-consciousness letters, other times like focused analyses, and they tend to increase the researcher's sense of confidence and competence, according to Charmaz (2006).

In theoretical memoing, I recorded in memo form the ideas I had about codes and the relationships among them, categories, and properties by constantly questioning data and making the connection between what I was discovering in the data and what I knew and had experienced. I analyzed the data by hand, with adapted Persian software to assist me in data management.

Theoretical sampling is defined by Charmaz (2006) as a strategy for finding pertinent data to develop the researcher's emerging theory and not to represent a population. Its purpose is to "elaborate and refine the categories in your emerging theory" (p. 96).This endows grounded theory studies with their analytic power. In this step, the researcher returns to the field or seeks new cases to develop and expand categories. Again, as described by Charmaz, theoretical sampling helps grounded theorists gain rich data, fill out theoretical categories, discover variation within theoretical categories, and

define gaps within and between categories. Theoretical sampling aims to sharpen concepts and deepen analysis to help the work gain clarity and generality that transcends the immediate topic.

I addressed the use of theoretical sampling with respect to sampling adequacy and data saturation earlier. I maintained an interaction between what was known and what I needed to know through the development of a data analysis log. Entries were dated as I prepared them and shared with my supervisors on a regular basis. I tested new ideas to see how well they fitted the data collected by constantly checking and rechecking (Morse, Barrett, Mayan, Olson, & Spiers, 2002).

The last phase in grounded theory is to integrate the analysis. This involves putting the memos and data together in an order that makes sense to the researcher. In this respect, I created the order and made connections for the reader. In this last phase, I attempted to reflect the logic of a participant's experience and provide authenticity. The steps vary, so I sorted the memos by category title, mapping the ways in which the ideas connected and choosing an order that worked for the analysis and the prospective audience. Grounded theory interviews are used to tell a collective story, not an individual tale told in a single interview. The power of the grounded theory methods lies in the researcher's piecing together a theoretical narrative or model that has explanatory and predictive power.

To finalize the model, I sought information in the literature, as the theory must be able to explain the data under study (Glaser & Strauss, 1967). The emerging model was backed up by many studies regarding immigrant and refugee populations through the world in general and in Canada in particular.

Rigor, Validity, and Reliability

Qualitative researchers have different criteria for reliability and validity. In all research, some criteria, such as truth value, applicability, consistency, and neutrality, must be met for the research to be considered worthwhile (Guba & Lincoln, 1981; Morse et al., 2002). Rigor, or trustworthiness, is vital to any research. According to Morse et al. (2002), "without rigor, research is worthless, becomes fiction, and loses its utility" (p. 2).

Lincoln and Guba (1985) stated that trustworthiness is a response to the reliability and validity criteria of qualitative research, and addresses the question of whether to pay attention to research findings. Aspects of trustworthiness in qualitative research are truth value—credibility—which is similar to internal validity; applicability of the findings to other contexts or other subjects—transferability—which is akin to external validity; consistency of the findings, if the study were repeated—dependability—which is equivalent to reliability; and neutrality of the researcher—conformability—which is similar to objectivity. To ensure credible findings Lincoln and Guba (1985) suggested five techniques: prolonged engagement, persistent observation, and triangulation; peer debriefing; negative case analysis; referential adequacy; and member checking. I had prolonged contact with the participant to build and maintain trust. I had the opportunity to have second and third interviews with some participants and spent many hours on each interview while I tried to interpret body language and gestures made during the interviews. To obtain peer debriefing, I checked out my perceptions with my friends, colleagues, and supervisors. I used negative case analysis to revise "hypotheses with hindsight" (Lincoln & Guba, 1985, p. 309) and employed member-checking by talking with participants to be sure that I had understood what they meant.

Morse et al. (2002) challenged these criteria. They asserted that to address rigor, researchers should use strategies inherent in each qualitative design and that rigor must be built into the qualitative research process. They stated that it is the researcher's responsibility to conduct reliable and valid research by implementing integral and self-correcting verification strategies to attain rigor. This "moves the responsibility for incorporating and maintaining reliability and validity from external reviewers' judgments to the investigators themselves" (p. 1). Using this approach, the researcher attains validity and reliability through the use of verification strategies (investigator responsiveness, methodological coherence, theoretical sampling and sampling adequacy, an active analytic stance, and saturation) (Morse et al., 2002) in the process of inquiry. By doing so, the researcher is forced to correct both the direction and the development of the study and to be sure of its reliability and validity.

To conduct a valid, reliable, and, as a result, rigorous study, the researcher tries to be creative, sensitive, and flexible; does ongoing analysis of data; and uses purposive sampling. Sampling must be appropriate, and respondents should be knowledgeable and very coherent. Purposeful or theoretical sampling helped me to select informants who had good knowledge and experience, and were willing to be interviewed. Because informants were chosen in different ways, the data were rich, and the criterion of adequacy was reached.

In my study, validity and reliability were addressed using the process proposed by Morse et al. (2002). I am an Iranian and thus understand the language and culture of Iranian immigrants. At the same time, I am fluent in English and am a serious student of grounded theory methodology. These factors helped me to be responsive in relation to

creativity, sensitivity, and flexibility with respect to the participants, the data, and the emerging theory. In qualitative research, the issues of sensitivity and objectivity must be taken into consideration. By being an insider and knowing the Iranian culture, I was positioned to be sensitive. However, this unique standpoint might also lead to a loss of my objectivity. To overcome the tension between objectivity and sensitivity, I was open and listened carefully to capture the respondents' voices. Prior to beginning the study, one of my colleagues had agreed to interview me regarding my perspectives, so that I became aware of my biases and was more easily able to identify times during the analysis when they might inadvertently overshadow my data.

I obtained methodological coherence by maintaining congruency between the research question and the components of the method (Morse et al., 2002). I accomplished this by carefully justifying the congruence between my research question and constructivist grounded theory, the method to be used in this study. Based on grounded theory, I adapted interview questions based on what I needed to learn and/or verify at any given point in the research process. Consequently, I talked with the interviewees as necessary following the initial interviews. I continued interviewing until the information became repetitive, indicating that saturation had been achieved.

Limitations of this Study

Because participants were recruited from a population of Iranian immigrants in Edmonton that is small compared to the Iranian populations in Toronto, Montréal, Vancouver, and Calgary, one limitation of this study is related to the representativeness of the sample. The second limitation is the level of education. Of the sample almost all of the participants were well educated, and so the results might have been different if people

with lower levels of education had participated in this study. Finally, Iranian immigrant populations are not homogenous; in larger populations, the results might be different. This study involved only Iranians who could speak and were fluent in Farsi (Persian). Some Iranians who spoke Balouchi, Kurdish, Arabic, Lori, Azari, and Gilaki as their mother tongue and were not fluent in Farsi or English were excluded from this study.

CHAPTER IV: FINDINGS

I began this study hoping to understand the process through which Iranian immigrants access health care services. Morse and Richardson (2002) mentioned that "Grounded theory research does not require any particular data source, but it does require data within which theory can be grounded" (p. 56). Data drive the analysis and interpretation of findings. Data analysis started with coding after the first interview. Using a constructivist grounded theory approach, "Tackling the Stumbling Blocks of Access" emerged as the core category. The basic social process (BSP) of "Becoming Self-Sufficient," has five stages: "Becoming a stranger"; "Feeling helpless"; "Navigating/Seeking information"; "Employing strategies"; and "Becoming integrated and self-sufficient." This process explains why some Iranian immigrants are able to use Canadian health care services effectively whereas others cannot. Each stage is described in detail in this chapter with the support of direct quotes from the interview data. Pseudonyms are used to protect the identity of participants.

Stage 1: "Becoming a Stranger" (Starting Point)

This stage had 3 phases: Ignoring one's self; getting lost; and becoming disconnected. During this time, participants disconnected from the ways they had previously accessed services.

Phase 1: Ignoring the self

Because of the collectiveness valued in their culture, Iranians put the family's need first (*khod raa faraamosh kardan, khod raa aakahar list gozashtan*[a]). In addition, because they had passed the screening tests required for immigration, participants thought that they were healthy and that there was no need to worry about themselves. "Settling

[a]) See Appendix F for equivalent Persian expressions.

in" kept them busy, and they ignored their own health and need for health care.

Participants talked about their experience by stating that:

> **Mahnaaz**: Since all of us had our screening tests before coming to Canada, we thought we don't have any health problems to be worried about and we didn't try to find out about it. We had lots of things to think about and lots to do, such as rent a place, kids' school registration, finding a job and the like. Thinking about having health insurance and how we can get services were not our priorities.

> **Simin**: I had lots of things to be worried about other than my health: finding a job, learning the language, helping our kids to cope with the new schooling system and their health—there was no extra time to think about myself…I put myself as the last person on the list…I would even say I was not on the list.

> **Pari**: Well, in Iran, I had an IUD. Sometimes, I had some spotting and the gynecologist fixed it…Awhile after I had some bleeding that my doctor couldn't fix and then she took the IUD out…and did curettage. I was OK and again I asked for an IUD. My doctor said that because I had some bleeding, it was better to visit her every 4 to 6 months for follow-up. Everything went well back home. I did my last check-up before leaving Iran and my doctor said that I was OK, but she insisted that I should do it in Canada. In Canada, you know…I was so involved with getting settled and getting all the paperwork done…taking care of the kids….I almost forgot to take care of myself…and whenever I thought I should follow my doctor advice and have a check-up….I just ignored it.

> **Minou**: You know…things happen when you are not ready for it ____ 2 months after coming to Canada a friend of mine invited us to her house for dinner…to make the story short ___ there was a stone in the rice and I bit it and one of my teeth got broken…I couldn't tell my friend and didn't want her to feel guilty___ I did not want to tell my husband about this because I knew we could not afford to fix it…we had financial problems…and my husband wanted to write his TOEFL…We needed money for that…My kids were about to start their school and we needed to spend money for their books and so on…So I just ignored myself and I felt guilty about telling them what happened to me____ But after 2 years I got such a big abscess and went through 3 surgeries and spent a fortune for it and for its treatment and for antibiotics.

These quotes revealed that participants put their families' needs ahead of their own health.

Phase 2: Getting Lost

On arriving in Canada, the participants were given many forms and pamphlets about health care in English, French, and other languages that they did not understand. None were available in Persian. Usually, the participants were misidentified as Arabs or Pakistanis. Information pamphlets were very long and written in a small font. Participants said that they were overwhelmed with information that they did not understand and did not have time to read (*goom shodan, sar dar nayaa wordan, beyne zamin va hawaa bodan, sar dar goomi, sar gar doni, nemidoni kojay in system hasty*[b]). Most said that although some of them could read and understand some English, English was not their first language and they could not read quickly or understand the information. In addition, for cultural reasons, they did not really take that information into account based on their experience in Iran. In Iran, pamphlets were full of empty offers that were not dependable. One participant remembered getting some information on arriving in Canada:

> **Pari**: but we didn't take it very seriously. They gave us some forms and fact sheets to read. First of all, our English wasn't that great. Secondly, we thought those forms weren't very important, and they didn't emphasize that we should read them. We thought those forms were full of superficial facts and empty promises. You know in Iran, we do not rely on written promises given by any organization. They are full of wrong and superficial information and lots of empty promises, which, if you follow, might get you into trouble. We weren't told that we had to read them and follow them step by step. I guess our friends didn't know either, and they got their information from their friends and passed on what they knew to us.

> **Saayeh**: I remember that I was referred to a Pakistani case manager. He spoke Urdu and I didn't know any words in Urdu. I told him I am from Iran and speak Persian. He said that he is going to make a temporary file

[b]) See Appendix F for equivalent Persian expressions.

for me and in the meantime he would try to find a Persian case manager…After 3 days I got a phone call that they found an Iranian case manger and I can meet him. Again, another mistake: He had some knowledge of Persian but he couldn't speak and understand Persian at all. He was an Arab social worker. I was frustrated, tired, and I thought…God...it didn't seem right…I couldn't believe this mix-up…how come they couldn't find the right person? I told him please help me to get out of this vicious circle. Please tell them I am an Iranian, come from Iran, and speak Persian (Farsi), not Urdu, not Arabic…just Persian.

Mahnaaz: They gave me lots of paper in small print in 4 or 5 different languages. I guess in English, French, Spanish, Chinese, and, of course, Urdu. I didn't have any idea about them, and it was Greek to me. I could understand just a bit of English. When I looked at this mixed-up information, I wasn't eager to read them…even the English version. You know I was so tired and anxious and I got overloaded with a tremendous amount of unnecessary information…It was too much…I got confused…I just put them aside carelessly. On the other hand, in Iran we never rely on this kind of information. No Iranians take them into account seriously, and it is kind of our habit. We are not used to reading papers, advertisements, and the like. That's why in here, in Canada, we get into trouble, and each of us has some stories to tell in this regard.

Phase 3: Becoming Disconnected

Most participants mentioned that upon arriving in Canada, they started feeling disconnected from their familiar world. Things did not make sense to them at first. Many participants knew individuals who found this experience so frustrating that they went back to Iran, leaving their spouse and, in some cases, their children behind. These individuals "turned away" and became "disillusioned". Those who could not go back to their homeland country because of their political backgrounds, religions, or financial limitations became isolated.

Ghazaaleh: Well it was like…I was an ET from another planet. Even making tea and coffee seemed to be different, let alone going to doctor. It took me a long time to stand on my own feet. I didn't know what I should do or shouldn't do, or whom to ask. I thought I was living in limbo. Even among Iranians, some of them are here for a long time and even the things that they consider as Iranian culture didn't make any sense to me. We are

younger, and in Iran the young generations have their own culture. To be honest with you, I was lost and felt like nobody in the middle of nowhere. I didn't fit in with Iranians (because they were older and were from the old school), and I wasn't matched with Canadians at all. I was lost; because the things older Iranians called "Persian culture" did not make any sense to me. I was walking between two cultures and yet couldn't find my place in either of them.

Rezaa: Well, every thing was new to me, I felt kind of stupid. I was so nervous. I lost my self-confidence, which made me more incapable. For every single thing, I had to check with somebody about what is the acceptable way of doing this and that. And still I always got that kind of look from Canadians which made me want to puke. I wanted to shout and tell them, "Please I don't know English," or "Yeah I do have an accent but it doesn't mean that I am stupid or I think with an accent." But I didn't say even one word....I thought, "What the heck is going to make any difference"...except if they get hurt they have the power to give me a hard time and make my life hell.

Nasrin: My husband just couldn't take it. He was struggling with every single thing and he didn't want to change the way he was familiar with. He asked me to return to Iran with my little daughter. I said "no"..."no way"...I know it is hard...it is really tough but I do my best to get through this for my little girl's future and for my freedom. Well, he made his decision and he went back to Iran. Although in Iran they fired him and he doesn't have any job, as he was in here, he doesn't feel homesick or I would say he was lazy and he didn't want to take on new challenges in his life.

Parviz: Well, you know it is not easy to learn new things when you are not very young or at least were settled for a few years. Our friends couldn't make it. They left Canada after 2 years and now they are living in Iran. They always told us we had different expectations. The things we knew and heard about Canada weren't the same things that we experienced.

Sharaareh: Because of terrible headaches I needed to see a specialist but it took about 5 months and I had to leave my job because I couldn't take any more time off and I could not continue working with headaches. Day and night I stayed in bed and in a dark room. My husband was very worried and asked me many times please...you go to Iran and get treatment there. I will stay here, you go. He cannot go to Iran because all

of his family got killed or prosecuted by the government. We left because we knew that they would do the same to him and to us because of his family. It is awful…you know…you are living in limbo…you don't know what's going on and why…nothing…God…I am just…God…I cannot say anything [long silence]…I don't know how to convince myself and find an answer…why we should pay this price without any reason.___ I had a friend who was a pharmacist, and I asked him to send me some strong medications.

Pari: I was soaked in blood. My blood pressure was so low…I was pale and about to faint…The doctor asked silly questions …Her questions just struck me like a rocket. I was soaked in blood and she asked…"How severe is your bleeding?…How many pads do you change in a day?"…I just looked at her and said, "You mean, you don't see I am bleeding like a waterfall…I am this pale and my blood pressure is this low…what's wrong with you? …You mean the color of your blood is different from mine…or what? Or, maybe because I have an accent I have an accented bleeding and you cannot see what others can see obviously"…[Laughter]…She was a like a machine gun and just asked questions that she had memorized no matter whether they were applicable to me or not…I couldn't understand and absorb it…I said to myself "here you go"…"welcome to Canada…the land of knowledge and technology!!!"…How I can trust her and accept her as my doctor? If she was a good observer, she wouldn't ask such stupid questions. More than a thousand times, I cursed myself…I shouldn't have left my country…at least I wished I had the opportunity to go there and get my treatment done in Iran.

Stories of Disconnection

The health consequences of disconnection can be significant. Limited doctors who accept new patients and long waiting lists in medi-centers were reasons why immigrants were reluctant to visit physicians. Many immigrant mothers deferred or postponed going to the doctor's office because they had children of various ages, and without help and without relatives around, it was really hard to manage the time to go to the doctor's office. It is difficult to take children with them on long trips to the medi-center. In addition, those who had children at school could not leave them alone in the

house or take them out of school. They traded away their health because there was no way to make it to the doctor. By the time they went to physicians, they were very sick. Many women worked to contribute to family income, took care of children, did house chores, and participated in English courses, which made it almost impossible for them to think about their health issues. In those circumstances, the last priority was to consider their needs in general and health needs in particular. They mentioned that they were hesitant to visit doctors because if the government found out that they were sick they would be deported to Iran.

> **Mahnaaz**: I had a neighbor from Iraq. They were Kurd. We are Kurd too. We could speak Kurdish. Well, she had a pain in her chest. Many times I told her go and see a doctor. She couldn't make it. She was working in Superstore far from her house. Many times she asked to transfer to the Superstore that is closer, but the manager wouldn't do it. He said we need hands here not there. Anyways she had 2 kids aged 2 and 4.5 at home and 3 at school aged 7, 8, and 10. She was working on an hourly basis and she was working in a packing site. She couldn't get lots of leave for a doctor's visit. The manager didn't permit it. The possibility of losing her job was really high and she didn't get paid for leave time. All these situations together made her ignore her pain. She was getting weaker. If you looked at her face you could see that she wasn't well. Then she started coughing which bothered her coworkers and then she visited a doctor. Well…it was too late. She diagnosed with advanced breast cancer. She went through massive surgery, mastectomy, and radiotherapy. She lost her job and didn't have any support from work. Hospital social workers tried to support her financially and emotionally. She died last year and left all of her kids behind alone. If she could have gotten help earlier, the cancer could have been diagnosed earlier and she could have survived the same as other breast cancer survivors. When you look at the whole picture they could have managed her situation more cheaply and she could even have taken care of her kids and the kids could have a mother to take of them. The kids have been adopted by different families and they are separated from each other.

> **Payaam**: I had a stone in my right kidney, and I was not aware of it…it was asymptomatic. All of a sudden I felt a sharp pain in my abdomen. The pain was incredible. And I went to the washroom and had lots of blood in my urine. I was shocked. I didn't know what to do. I didn't want to go to

> the doctor. I didn't want to talk to my case manager. I had heard that if they learn that I am sick, they will deport me to Iran. I was so hopeless …helpless. One of my friends told me, "Call an Iranian physician here and tell him your situation I am pretty sure he is going to treat you." I found his phone number, and he said, "I cannot help you over the phone…You have to come here and I will help you." I got an appointment and when I told him about blood in my urine ….he said, "Probably you have a kidney stone and you have to do this blood work, urine test, and kidney X-ray and sonography." So I was under social services and I was afraid that they would find out that I have a kidney problem. I asked him if it is possible to be treated without doing tests. He said, "No, I cannot treat you without tests." Then I left his office. I was very upset and hopeless, didn't know what to do, where to go, and who to talk to. I just ignored my problem. It didn't bother me for a month. But all of a sudden I had the same terrible pain in my abdomen and had massive bleeding. I thought the only person who could help me was the Persian doctor, and I called him again. He said, "You should come here right away and I will see you as my last patient." He said I had to do those tests…he said, "There is no way around it and your condition is getting worse and you might lose your kidney." I was hesitant. He sat in front of me and looked me in the eye and asked me, "What is your problem…why don't you want to get these tests done?" I told him that I was a refugee and I had heard that if the government learns that I have a health problem, I will get deported. He looked at me and said …"No …no way …you are sick and you need treatment." He said that was not true and that I shouldn't listen to others—always check with a professional. He assured me that the government would not deport me because of some tests. I was so happy…It was such a relief…He gave me some pills.

Stage 2: Feeling Helpless (Entry Point)

This stage had 2 phases: Needing access to health care services; and Facing barriers.

Phase 1: Needing Access to Health Care Services

Because immigrants were healthy when they came to Canada and were busy with "settling in," they were usually not prepared to face health problems for their children or for themselves. Their first contact with the health care system usually arose at a time when their health problems were acute and health care assistance was required quickly. Fear and feeling hopeless (*ehsaase naa omidi kardan, naa omid bodan, naa omid shodan,*

ghate omid kardan, ghate omid shodan, az hame jaa va az hame chiz ghate omid kardan, az hame jaa va az hame chiz ghate omid shodan[c]) and helpless (*ehsaase bichaaregi kardan, ehsaase naa tavaani kardan, raah be hich jaaee nadaashtan, ehsaase darmaandegi kardan*[d]) were common as they tried to work out how to deal with Canadian health care services. Limited knowledge of English, financial limitations, and a lack of understanding about how the Canadian health care system worked intensified these feelings (*nemidonestam kojaa beram, nemidonestam be ki moraaje bekonam, nemidonestam baa ki harf bezanam,, nemidonestam chiro baayad be ki begam, mesle in ke tu taariki raah miraftam, man hichi nemidonestam, az hich chiz sar dar nemioowrdam*[e]).

> **Baabak**: I was shocked and hopeless…I didn't have anybody to turn to when I had problems in Toronto. I was suicidal and I attempted suicide after all those hard times. All of a sudden I made the decision to leave Toronto and go to a place where nobody knows me. Therefore, I left Toronto and came to Alberta. Here, I got some help from my case manager. Although I experienced language barriers, I was sure that my secret would stay private and I wouldn't go through the same thing I went through in Toronto. You know there were lots of misunderstandings, misinterpretations between me and my case manager, but a good point was that she gave me time to explain and even used body language for communication. My case manager and social worker were really patient with me. I couldn't get any help like this from anybody, let alone from Iranians. I couldn't ask for more.

> **Saayeh**: [A] day later, around noon, we got up. I felt pain all over my body…I hardly could move. I checked my kids' temperature…Oh my god…they were burning like a furnace…I got anxious…I didn't know what to do…I had lost my self-confidence…I felt helpless.

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[c]) See Appendix F for equivalent Persian expressions.
[d]) See Appendix F for equivalent Persian expressions.
[e]) See Appendix F for equivalent Persian expressions.

Parviz: I had to start everything from scratch…I mean I had to know a new language, start to learn and get some informal or formal education and try to find a job even unrelated to my previous field in Iran.

Baabak: It is like a "catch-22" situation with English health care providers and physicians. It is very overwhelming.
Tinaa: The long waiting list was another issue for us. We didn't know that there were other ways of accessing family physicians. We thought they only place is just a medi center close to our house.

Saayeh: A nurse called me and said that because it was our first time and our file was empty, they needed some information about my kids and their health history to make a file. She started asking some questions about my kids' illness and their diet…honestly I didn't have idea about most of them. Whenever she asked a question, I turned to Af and asked her. Sometimes she knew, sometimes she didn't…It was the most frustrating time for the nurse, my kids and myself. It was so strange for nurse that I double-checked almost every answer with my older daughter. She asked me about their immunization history, and I just looked at her and said nothing and asked Af, and she said "I cannot remember anything." The nurse couldn't believe that a mom would know almost nothing about her kids' life…she thought oh my god such a careless mom. Suddenly she got anxious and she got mad at me and said, "Are you a mom or a step mom?"…I was in a very hard situation. I didn't know how to deal with this situation. All of a sudden I found myself in a trap…I really got stuck between a rock and a hard place at that moment….When the nurse told me that, I broke down. It was the most shocking situation for me. I didn't know what to say…I was crying and left the Medi center…I promised myself that even if I'm dying or my kids are dying, I will never ever go to any Medi center or visit any doctor…I knew that I couldn't make it next time if I was questioned again. You know, these things are very far from reality and hard to understand for people here. Sometimes you cannot share your story with them because they cannot understand it. I couldn't tell them I was in jail, but I wasn't a drug dealer or a criminal. Political prisoners are worshiped by many people in Iran, but here it is totally different. This young lady (22-23 year old) who was born here thinks whoever comes here (Canada) has physical needs such as food and they are illiterate. I am here to survive, and I just ran away from death.

Sharaareh: Well…being in the emergency room because of being in real trouble is different from just dropping by there and getting regular services. Being new and having communication issues make the emergency room like being in hell. When I was in emergency I felt helpless and didn't know what to do and who to talk to. After being in a

> long line, a nurse came and ask me to sign a paper and I did it but I didn't know what it was for and what it said…I just signed it and then she asked me to put on a gown and stay in a small room. It was freaking cold, and I was there for a good 4-5 more hours. Meanwhile, she just came to my room and checked on me and left me in such a hurry. I even didn't have a chance to see her face. I was sitting there, waiting and waiting. Nobody came and talked to me…I was in such a fever and I was shivering in that little dark and cold room in a very loose gown. I could manage to talk to one person over there, but he said I had to stay in my room and then they will come and take you to the physician. I was so disappointed and I just blamed myself for being in this country. I couldn't understand this much ignorance and felt dehumanized and undervalued.

Phase 2: Facing Barriers

Each participant faced at least one barrier. These barriers pertained to communication/language, finances, cultural differences, and time orientation.

Communication/ Language Barrier

The language barrier was one of the most prominent barriers to accessing health care services. Immigrants with limited English proficiency could not express what they wanted and verbalize or explain the help they needed to health care providers. In addition, the language barrier barred them from knowing about how the Canadian health care system worked. It blocked them from finding a job and having financial freedom, which directly affected their health, as they could not obtain insurance coverage. They missed doctors' appointments because they could not communicate with nurses and doctors. Making doctors' appointments was one of the most frustrating, disappointing, and unsatisfactory experiences. One participant said that to get services, first they have to break the wall of the language barrier.

> **Simaa**: Language is not a barrier for me, because I got my degree in the UK. But I can remember how hard a time I had in the UK. Now, I am doing ok because I experienced this situation before and I can adjust

myself faster and quite well. To get integrated into a new country, knowing the language plays an important role. They have to be helped to learn the language and break the wall of the communication barrier.

Tinaa: I don't feel comfortable seeing a doctor. They use lots of medical terms that I am not familiar with and I don't like ask too much and always ask to explain it for me. I even wonder if all Canadians know medical terms and if not, how come they persist in using them. Perhaps nobody taught them at university about health literacy and that people with limited knowledge of English for sure have more difficulties.

These negative experiences and the lack of understanding of the health care system triggered further frustration and affected immigrant patients' attitudes towards Canadian health care services.

Rezaa: Well…I cannot get it. I was on a long list to see a specialist. It took about 5 months but he spent 10 minutes with me. When I asked some questions he didn't understand me and he told me, "well my nurse will help you and answer your questions" and he walked toward the door and opened the door for me with a big smile…I felt humiliated but I didn't know how to react and make my case…it meant "please leave and I don't have extra time for you"…and turned to the nurse to see her reaction…she had a big smile too…I couldn't take any more humiliation and I left the office without asking my questions…and the nurse didn't bother herself to ask me what I wanted to know…You know I didn't trust this doctor. I didn't bother myself to follow his prescriptions. I used some medications I had with me from Iran….And one night BOOM…I had a stroke…my poor wife…she went through hell until she got help…well besides having language barriers, I got good care in the hospital…no more complaints.

Nasrin: Oh my god going to the pharmacy is a stressful experience. You go there, they talk like a machine gun and talk very fast. I was freaked out. Anyway, he attached a long page written very small about the medication and its side effects and lots of extra information. First of all, I couldn't understand it and when I asked my friends to help me to understand I was freaked out. I didn't want to take it.

Rezaa: You know as immigrants, for the first 3 months we don't have insurance. After 3 months we can apply for it. I was very unlucky, because I got appendicitis and I didn't want to spend all my money for this…I was very new to this country…umm well exactly it was about 2 and half months…and I didn't have a job and even our paper work wasn't quite

done yet…Umm…my kids needed to go to school. It was devastating. I just took some pain killers to lessen the pain. The pain was off and on. Luckily, we got our insurance card. Umm…oh god…I cannot forget that night. All of a sudden I had a terrible pain in my abdomen and then I felt something ruptured in my abdomen, I mean inside…I was vomiting…I got dizzy and all of sudden I collapsed and then I cannot remember anything…I was unconscious…My wife…poor her…was crying over my body and couldn't do anything…she couldn't speak English…and we hadn't had enough time to form friendships…So there was no help. Although we were told in case of emergency to call 911, my wife didn't call them because she couldn't speak English…She just went out…in the street and cried out loud to catch people's attention. Finally, a couple asked the police to come and see what was going on in our apartment. In the meanwhile, out of nowhere, an Iranian guy was passing on the street and heard the police talking and saying that the clients cannot speak English. He asked them, "What language do you mean? Can I help you?" The police said "We don't know…Could you please go in and check it out"…He was like an angel…My wife couldn't believe it…he was Iranian…My wife was shocked and couldn't believe it…He was my life saver. He stayed with my wife and me in the hospital and asked his wife to take my kid to her house…Practically, he became our translator and our advocate. The physicians in the ER sent me to the OR because I had a ruptured appendix…I was a month in the hospital because of infection and many problems. My whole treatment took 6 months. Still, I paid a lot because of the cost of medication. It was a total disaster. You know that was the point. My wife and I learned that knowing the language is not just a privilege. It is a must.

Shaadi: The nurse took me into a room and asked me to put on a gown. I was waiting for the doctor to come and visit me for 3 hours. It was so cold and I was shivering but I didn't know how to tell her...I didn't know how to ask….I thought maybe my request was impolite. I was just like a frozen statue…and I was just crying.

Ghazaaleh: Some health care providers don't like us. They think we are problematic patients and we are not compliant clients. I felt kind of lost. One time I was in the doctor's office and the nurse put me in that little room. I felt kind of disconnected from the world. I felt I was a different creature in this country. She didn't come and check up on me. I can't really trust the providers.

Aarash: At the very first when I came to this country, going to the doctor meant nothing to me…I couldn't tell them what's wrong with me…I didn't think that was going to solve any health problems that I had.

Pari: I had communication problems. I couldn't understand their questions. I couldn't exactly get what they meant. My answers to their questions just made them confused and it wasn't informative.

Simaa: It is not just about visiting doctors and getting a prescription …Well, sometimes the real problem is to understand how to use medications and about their side effects and preparation for more tests. There are many areas where you need good English proficiency to go through the health care services and get matched.

Pari: You know because our English is not good, sometimes our explanations just make doctors more confused rather than being helpful. There is a proverb...it says…"a little knowledge is dangerous"....you know... that's why I think communication, I mean a good communication, is a key. I experienced it for my kids and for myself too.

Shaadi: At the clinic, they asked about some forms, I didn't understand what they meant. I asked them to write it down for me, and then I checked it with my kids. They could read but they couldn't help me because they asked for some special forms with special names…It was very technical. I was wondering if all Canadians understand them.

As a result of communication and language barriers, participants said that they could not trust health care providers and services. In addition, they mentioned that available services did not meet their needs appropriately.

Minou: Health care delivery in Edmonton is very poor, because health care providers do not really work closely with their clients.

Ghazaaleh: I am not happy and satisfied with the health care delivery here. Health care providers in clinics and doctors' office are rude; especially when you look poor or you have a heavy accent.

Sharaareh: Based on my experience, health care services are run poorly and inappropriately. There is a lack of support from the system, and providers are ignorant or mean. Health care providers need to be more patient and understanding of clients. Whenever I want to make an appointment with my doctor, there is an answering machine that tells me what to do next. I am kind of lost; sometimes I don't understand what it says. Anyway, when I leave a message it takes at least 2 or 3 days for

them to return my call, because the centre is very busy. I am getting scared of the system. If I get sick I am not going to stay in the hospital. It is like a nightmare. I don't know what to say and how to talk about my issues and concerns. People who cannot speak the language aren't treated well in doctors' offices and hospitals. I don't really know what kinds of services are available to me and how I can reach them.

Nasrin: The thing that I cannot understand is why it is so hard to visit a physician or a specialist. You know I always try to do all possible things to relieve my health problem and the last choice is seeing a doctor. It is strange because when I was in Iran I never did it…I always followed my doctor's recommendations. I did not follow any unprofessional advice…but here…in Canada…in one of the best developed countries in the world my last choice is seeking doctors' advice. Gosh when I think of making an appointment and still sitting in a waiting room for a good 4 hours for just a quick 10-15 minutes visit…forget it…it is too much.

Pari: When we were in Iran, my kids had their own dentist for years. Before leaving I asked the orthodontist fix their braces. Every thing was fine, but after a year, they grew and they needed another fixing. I didn't know who is a good dentist. I asked my friends. They couldn't help me because they never have this problem. I was so frustrated. I didn't know how to explain all those long procedures to new doctors. On top of that, I knew the technical words in Persian but I didn't know what would those would be in English. I was hopeless…I was helpless….I couldn't sleep…I had such a nightmare. Finally, it came to my mind to search in the yellow pages….I started to search it with no help…to my amazement, I saw an Iranian dentist. I called her office and took my kids over there. She understood Persian technical words because she worked in Iran for some years. Since then she is our family dentist and all of us are satisfied with her services. She is really caring.

Although having an interpreter helped some patients to tell their physicians about their problems, they also mentioned it as a source of marginalization and discrimination. They felt that physicians almost forgot their presence and communicated with interpreters, not with them. They mentioned that they, not the interpreters, were the patients. Interpreters are there as mediators and should not be the center of physicians' attention. Participants expressed that the physicians should look at and talk to them rather

than carrying on direct conversations with interpreters. They stated that it was a humiliating experience that caused them to lose interest in asking for interpreters.

> **Mahnaaz**: One time after many arrangements, I got the opportunity to have a Persian interpreter but I felt awful because the doctor didn't look at me; he was talking to the interpreter as if I was not there, and the interpreter talked to me. It was strange because sometimes she talked longer and sometimes the conversation just was between them. I felt belittled, humiliated, devalued, and embarrassed; I could see how satisfied the interpreter felt, and how important she thought her role was in my life. Well, from then I never asked for interpreter, I took my son with me. Of course, it was not convenient but the atmosphere was more comfortable.

> **Sharaareh**: Although having a translator is very helpful, the problem is that the doctor looks at her when she asks questions and always talks to her. I am like nobody; I think I am not there. All of a sudden, the interpreter is the center of attention, not me. I am the most ignored one and from that point I changed my mind. First of all I don't ask for an interpreter; secondly, I don't go to see a doctor. I ask people who consider my being as a person and look at me as a whole rather than just language.

> **Tinaa**: I never forget the first time that I was in a doctor's office. The Catholic Social Service made an appointment for me to visit a doctor along with an interpreter. I could not understand anything. The interpreter and doctor talked to each other most of the time, and when they started laughing so hard, I was very upset and embarrassed. I couldn't take this disrespect and it was very humiliating and sometimes when I answered the question and she translated they look at each other and they gave me that kind of look…I mean that she is crazy and she is mean. From that time I never asked for an interpreter. I asked my friends to accompany me. Well they were better than me but they were not fluent in English either. And I wasn't comfortable answering all questions; I skipped many of them or gave them wrong answers. Well what I could do? It was terrible, because I knew that I didn't answer all questions and I was not honest with my doctor. Then whenever I used my medication I was always worried. I couldn't trust it, because what if I got wrong the treatment because of a wrong answer that I gave to my doctor? If something happens how can I fix it and how would be possible to tell my doctor, what is she going to think of me?

Participants stated that some interpreters were not trained and did not have enough knowledge of English. They mentioned that these interpreters could not help them with medical terms and technical words. In addition, they brought out the issue of trust. Participants said that they could not trust (*etemaad nakardan, etminaan nakardan, motmaen naboudan*[f]) an interpreter just because he or she can speak the language.

> **Saayeh**: Her [the interpreter's] English wasn't great and she didn't have good enough mastery of English to tell them what I really said. She didn't know medical terminology. My real problem was medical terminology, not simple communication. I could speak broken English because my university major was English literature. She didn't ask questions. She asked questions that she wanted to know about or she thought were important. I was upset and the doctor got confused because he found conflicting information (things I told him before and things she translated to him). It was a very frustrating experience for the doctor, me and the interpreter. The interpreter did her best but she wasn't trained for this. In short, whatever it was, it wasn't helpful at all. I said to her, "If you let me, I want to talk to my doctor and whenever I think I need your help I will ask for your help." As I remember, she couldn't help me much. I got a good lesson from this experience, and I said to myself, "Fasten your belt and solve your problems by yourself"; I had to try to be knowledgeable and find out what's going on around me and see what kind of resources are available to me.

> **Saayeh**: All of us were overwhelmed and couldn't understand each other. Finally one of the nurses called to a center and asked for an interpreter. Nobody was there. She left a message for them that they need a Persian interpreter. Well, the next day, somebody from the interpreters' center called and said it takes a bit of time to find somebody who speaks Persian. Well…they told me that they found a Persian guy who would be my interpreter. I was not comfortable to talk about my genital system and its problems with a strange guy who is not related to the medical group. If this guy was a nurse, doctor or in related field I wouldn't mind it, because people from these fields are professional. To me, there is no difference between a male and female doctor and their specialties but I never ever feel comfortable sharing my private things with a nonprofessional guy from same community…Well ___ I told them in this case I am not comfortable with a male interpreter. They said they were trying to find a female Persian interpreter. I think it took about 4 days for them to find a

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[f]) See Appendix F for equivalent Persian expressions.

> female interpreter. It was the day when I got discharged from hospital and I was waiting for last visit with my doctor when a nurse told me a female interpreter would be here to help me.

The interpreter should be known and be accepted by Iranians. Participants said that they are upset about this service, because it does not operate appropriately. Participants pointed out that as citizens of Canada, they have the right to use and have access to all available services. Some thought that the problems they experienced with translators might have been due to the fact that the number of Iranian immigrants, relative to other immigrant groups, is small, but they noted that this was not an excuse to exclude them and other small immigrant groups from available services. Participants mentioned different ways of getting help regarding the language barriers. Family members, relatives, friends, social services, and interpreter services were their selected sources for help in communicating with physicians.

> **Sharaareh**: I had a terrible headache in the morning…it was really bad and I could feel a pulsation in my head. I was vomiting. I wanted a have a checkup to see what was going on. Well I couldn't speak English and I didn't know how to make an appointment and how to communicate with physicians. I asked my friends, and they said they could come with me and help me. We are supposed to meet at the clinic that they usually go to. It was far from me but I had no choice because I knew nothing. I got there and sat for hours but there was no sign of my friend. I contacted her and she said her car had broken down, and because I didn't have a cell phone, she couldn't tell me what had happened to her and that she couldn't make it. Then I went back home and just took some painkillers. I had brought them from Iran. I was so upset but I couldn't do anything. Weeks later, while I was in West Edmonton Mall I saw one of my friends. She said "you are very pale, you are sick." She asked, "Have you checked by a doctor?" I told my story…and she helped me and took me to the clinic.

> **Baabak**: Although my assigned social worker is not an Iranian, she does her best to help me. She found an Iranian doctor, and I could discuss my health issues with him. Although I didn't know the language, I felt at home. Actually he was very nice and caring. I am satisfied with their support.

Some of participants were not satisfied with any of these sources. Participants in this study said that there are no full-time, trained Persian interpreters, or, at least, they are not aware of them. They mentioned that as far as they knew, there is a part-time volunteer. Having a trained interpreter who knows medical terms and procedures is critical to helping immigrants to get the help that they need.

> **Mahnaaz**: I gave up calling Centralized Interpretation Services because whenever I called them (in the afternoon) to get help and make an appointment for an interpreter, the answering machine started to play a long message. She talked very fast like a machine gun. I did not understand what she was saying and I gave up and did not try it again. This service was not helpful for me. If I could understand English, I would not need an interpreter. I could not understand the reason for having such a long and fast message on their answering machine. I did not try to leave a message because I could not understand it…It was very fast…Maybe if I left a message for them they would take care of it…but I did not. Knowing about procedures is a patient's right, and we cannot bracket people who cannot speak English well and ignore their needs. By having things explained to them and having their questions answered, they can cooperate better because they understand the procedure and they are going to follow doctors' orders before and after the procedure. Patient teaching is one responsibility of nurses and doctors that cannot be done successfully with a language barrier. The gynecologist made an appointment for 2 weeks later. She said she was booked tight and could not accept me sooner than 2 weeks. I felt really bad…I was sick…I didn't know what to do…where to go…I was so anxious…I wished I could talk to her by myself in our language and tell her how sick I felt and how much I needed her…My heart was broken…I didn't have any choice…. I was worried about my future…I didn't know her…How I could trust her…I didn't have any power to do something and make them help me. Many times, I saw some Canadian clients who made their doctors do things for them…because they don't have a language barrier…they know their rights…you know knowledge/information is power…language and communication is the key. All of those give people power and self-confidence. Obviously, I couldn't make my doctor do anything for me…I had a language barrier…I didn't know the system and its structure…I wasn't familiar with my rights…I was just powerless…helpless…hopeless. I was shy…I was afraid of doing something wrong and upsetting them…I didn't want them to think that I insulted them or I was impolite and rude but you know…I was in real need…Nowhere to go…nobody to talk to…. It was like being in hell…At that time I wished I were in my country and could do something

> for myself…I felt alone…nobody around…I was numb…I couldn't understand and absorb this situation…I was just shocked and I was frozen…Ummm…You know in Iran if you are this sick, there is a way to get quick service in a situation like that. When I got home I called my friend and told them, "I am not all right" I asked them to call to their doctors and explain my situation to them…they might see me earlier. They called but no hope…they couldn't make an early appointment for me. My friends did their best, but they had a language barrier too…like me, they couldn't make their point and explain my situation very well.

> **Sharaareh**: In a medi-center, each time, you might get a different doctor, and you will be assigned a different doctor on different days and at different times of the day. I didn't like it, but I didn't have any choice. Since I didn't know any of them, I didn't mind which one I saw.

While they were in Iran, participants were told by family members, relatives, and close friends that health care in Canada is free and is one of the best systems in the world. They assumed that everything, such as doctors' visits, hospitalization, tests, medications, eyeglasses, and ambulances, were covered by public health care. Some thought that as soon as they arrived in Canada, they would be covered automatically and would not have to apply for health insurance. They thought if they simply went to a doctor's office or a clinic, all services would be provided.

> **Tinaa**: Because of moving and carrying heavy luggage, my back hurt. I had very bad lower back pain, I hardly could move. I couldn't go and search for a job. I really should have visited a doctor. ____I didn't know what to do. I had no idea what's going on in here. It was about 2 months I was in Canada. I could hardly speak the language. I didn't have my public health insurance. I was told that I had to apply for it after being in Canada for 3 months. I didn't know that.____ I thought I was covered by the government. When I learned that I wasn't, I felt helpless. I didn't know what to do. I wished I was in my country, where there are lots of specialists available and you can get some help and not suffer this much. I bought some over the counter pain killer. Not only did it not help me, I also got some problem in my stomach.____ It was awful.

> **Shaadi**: I had a kind of pain in my chest…kind of heart problem. I didn't know what to do. I was told that if I asked for help from social services

they were going to report it and I would be deported. I didn't know the language. I couldn't explain what my problem was. ___ I was afraid of asking for help. I just used some pain killers that I brought from Iran. I was helpless and many times wished to die rather than being in so much pain and not being able to get any help.

Baabak: You know I came to Canada as a refugee. I was waiting for the court hearing. At that time I was in Toronto. After a year doing nothing, waiting for the result and being in such a cold country (You know ___I am from south of Iran which is very hot). I got depressed and I ended up going to night clubs and having unsafe and unprotected sex. I was very worried about getting some kind of disease (HIV). I didn't know what to do. At the same time, because of lots of pressure I got depressed…I guess my body was very weak and I got very bad flu. It didn't go away with simple interventions, such as eating some soup and drinking lots of juice and tea. This flu just freaked me out. I thought I had HIV. Oh my God such a nightmare___ I had never experienced that kind of flu. I was burning in fever like a furnace and losing weight and had pain all over my joints. I was really hopeless and helpless. I didn't know what to do. I had no idea. I was like walking on dark place and had no idea what's going on around me. I was really freaked out. I thought if I was positive…one thing was obvious ___They would deport me to Iran, and it was imminent that the Iranian government without wasting any time would kill me. That's why I didn't ask for help from my case manager. I thought dying from HIV is better than being hung. It was an awful feeling.

Rezaa: Well, my wife couldn't stay in here. She didn't want to come to Canada but she followed me. At the very first, we thought we could make it through. Every little thing was a big chore. One time, our little girl developed seizures. Because of the language barrier and not having enough money to buy medications, my wife couldn't stay in Canada anymore.____ Well, we felt awful, hopeless, and helpless and we thought in this situation we cannot help our little girl. We couldn't see her suffering any more. She took my little girl to Iran and she said she wouldn't be back to Canada. Language and having different ways of doing things and financial limitations, not being helped and supported and not having coverage were blocks that my wife couldn't handle, and she left with my little girl.

Saayeh: My daughter was sick and I wanted to take her to a physician and didn't know where to go and how to access family physicians….Well, I didn't know anybody and I didn't know anything about doctors' reputations, I didn't know how I can access a specialist. I didn't even

> know that it was possible to choose your family physician or specialist ___ I knew almost nothing....generally speaking I didn't know how things work.

Individuals who did not have problems with language faced different issues. This group mentioned that they had exposure to health care services other than the Iranian system while they were in European and North American countries. Those who did not have a language barrier still struggled to learn about the new health care system; it took time, but finally they made it through. Although they did not mention being or feeling hopeless and helpless at this stage of the process, they felt overwhelmed, exhausted, and sometimes even burned out. They mentioned that trying to get information from different sources was a chore. They had to find out what to do and how to do it. This was not an easy job, and it took a lot of energy and time.

Participants mentioned that when people are in their own country, they learn things as they grow up, but when individuals start a new life in a new country – one in which they can have all the services available to the citizens of the host country – they have to learn all new things in a very short time. Although some of these individuals experienced a language barrier, those who had lived in another country could apply some of the strategies they had learned previously and could access Canadian health care more quickly than those immigrants for whom this was their first exposure to a new system. The participants who had fewer problems due to previous exposure and language proficiency revealed that they had had the same experiences and had gone through the same processes, more or less, in their initial encounters regarding the need for health care once outside Iran.

> **Simaa**: Well, it wasn't my first experience using different health care services. My first experience was while I was in Germany with my family.

> They have a different system as well, different from here and from Iran. To tell you the truth over there, although I had language and cultural barriers and financial limitations, the system was much easier to go along with. I am talking about its design. Well we got lots of help and support from friends and government; without those I couldn't have made it at all. Even with all that help because of having a different language and culture there were moments that I felt so hopeless and frustrated. When coming to Canada the first thing I knew was___ oh yeah ___ everything was going to be different. It was a very overwhelming, and time- and energy-consuming chore. One thing helped me a lot to go through it better than my first experience in Germany was applying some of those strategies such as learning the language, communicating with people, asking them what to do, or telling them what you need.

> **Simin**: You know, I was familiar with the Canadian health care system a bit because I got my master's from the University of Alberta years ago. At that time, I got a lot of support from the GSA [Graduate Student Association] when I had any health issues. So I got to know it little by little and I didn't have any worries about what to do or where to go. But the second time that I came to live here, not to study, things were different. My previous experience with Canadian health care services helped me a lot to get through it but it was not easy. Lots of things you have to take into consideration that I didn't do the first time. Things that I should have taken care of by myself that when I was a student the University did for me. But ___ yeah my experience helped me a lot to get through. One big help was my supervisor. We kept in contact with each other while I was in Iran. When I came back to Canada to live, he supported me a lot and he offered me a research assistant job ___ which was a great relief and help. Although I knew the language, the country and its system somehow, I knew for sure that without his help I couldn't make this journey this much safe and sound (laughter)___ you know it is not an easy job___ It takes a lot of energy and time. Whenever I think back, I remember sometimes how frustrated and overwhelmed I was.

Financial Limitations

Transportation problems were a consequence of limited financial resources. Not knowing how to get to a doctor's office by bus, being far from the doctor's office or hospital without having car or not being able to hire a taxi, or having no sources of social support made it difficult or almost impossible to access and use health care services.

Minou: After a long time, finally I could manage to make an appointment on my day off to visit my doctor, and I arranged to have an interpreter and asked my friend to come to my place and take care of my kids while I was going to the doctor but I could not make it. It was frustrating. I didn't know how to get there. I called ETS and asked them which bus should I take…I guess because of my accent and my poor English I gave them the wrong address…or maybe I was mistaken and made a mistake…I don't know what really happened…to make a long story short…I was wandering all over the city from this bus to another bus for 4 hours, and then when I got there the office was about to close and they said I missed my appointment and I had to book another appointment…I was tired, sick to my stomach…it was cold out there, I felt helpless…and I told the nurse my story and asked if it was possible to get my doctor visit…she said I am so sorry, I am afraid you cannot….I told them "forget it...I am not interested in making another appointment." I felt terrible…on my way back home I just cried. I remembered the days back home when I got the acceptance letter from the Canadian embassy. I remembered how happy and healthy I was…I never ever even for one second thought of this day…If I did I might not have come to Canada…I knew something is wrong and shouldn't be like this...I thought it is unusual, otherwise there was a way to overcome it…I thought it was my problem. Many immigrants live in Canada and if they all go through the things I go…for sure the government would do something…then I told myself I am not gonna tell anybody what happened to me, and I didn't discuss it. I didn't want to be considered a foolish and stupid immigrant…then when I got home my friend asked me how it went. I didn't tell her the truth and I said it was ok…I thought if I share it with others, especially Iranians, I was going to lose face…I mean they wouldn't respect me as they normally did…It was my belief…I don't know. I didn't try the other way. Maybe I was wrong…maybe I was right…The problem with Iranians is they never ever say that they have this problem or that problem...They always say that they are perfect and it didn't happen to them…for example I know many of them have a level of English that is the same as mine but they never acknowledge it and say that they don't have any problems with it and they never have had any since they set foot in Canada…They and we all know that it is a big lie but it is the way it is…they are so judgmental too…It is our culture…always too proud and not asking for a lot of help and putting on a mask to hide the reality even with your very close friends.

Sometimes, participants had made many arrangements before visiting a doctor, such as booking an interpreter, asking someone to take care of the children or get them ready for school, getting leave from work, and asking their husband to give them a ride to the doctor's office, because they had a car and were more familiar with the city. One

participant stated that although she and her family did not have any coverage to pay for their medications, they asked their physician to help them and give them some samples.

> **Mahnaaz**: I am working part time in a low paid job and my husband is still trying to find a job. We have difficulty spending money for any medication. Whenever we get sick we go to the doctor just to be sure that we don't have a serious problem because we cannot afford to buy medications. Drugs are too expensive here. We try to manage our problems somehow. If things get very bad or serious we talk to our doctor who is very nice to us and she always gives us some samples which work very well. That's all you can do, you have to manage the situation and ask for help.

Cultural Differences

Cultural awareness, being sensitive to others' beliefs, values, and behavior, is extremely important for the delivery of care to all Canadians in general and to immigrants in particular. Participants noted that if hospital staff and other health care service personnel are not sensitive enough to non-White English-speaking immigrants, these people will avoid using the services, which will put their health at increased risk. The lack of awareness of cultural differences causes dissatisfaction and a sense that one is not understood, and is being ignored and/or discriminated against.

> **Nasrin**: Some questions and behaviors that showed me that they don't understand and have no knowledge of other cultures got on my nerves. Some of them, especially the young ones, thought that if something is different it is odd.

> **Shaadi**: When you are talking to them you have to start from somewhere as an introduction, they start to type something and looking at the monitor more than your face. By the time you are finished warming up and you are ready to talk about your problem, time is up, she/he is in front of you handing you a prescription and telling you to come back 6 months later…it is not fair, patients do not have the same rights as doctors. They start, they interrupt you and they end the conversation and ask you to leave the office…you feel terrible. I was excited and I was counting on seeing him and telling all about myself. I learned that he was not listening to me.

> I felt so stupid and I stopped talking. To my amazement, he didn't even ask me how come I stopped talking. It hurt. I never went back to his office. I lost my trust in him and for a long time I didn't see any physicians.

Some cultural values such as *khejaalat*[g] (shame, ashamed of not knowing, embarrassment), *ghorour* [h](self-pride), and *soale ziyaad yaa bi jaa kardan*[i] (bother people by asking questions) influenced Iranian immigrants' access to services. Usually, Iranians are ashamed of asking many questions and of asking for help. They do not want anyone, especially Iranians, to know that they have a language barrier and/or financial issues. Some do not like to share their problems and their private issues (*masaele khosoussi*[j]) with others, especially with other Iranians. They like to keep their problems private and share (*dar meyoon gozaashtan*[k]) them only with family and very close and trusted friends.

> **Baabak**: That's why I seldom communicate with Iranians, because I don't feel comfortable, though.

From the standpoint of Iranian culture, one does not ask for help. Rather, one waits to be provided with information. Many participants stated that because information regarding access to health care was not provided in a manner that they could understand, they did not know what to do when they became ill, and nobody told them (*chizi nemidonestam, kasi chizy be maa nagoft*[l]). They did not talk about their needs until they

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[g]) See Appendix F for equivalent Persian expressions.

[h]) See Appendix F for equivalent Persian expressions.

[i]) See Appendix F for equivalent Persian expressions.

[j]) See Appendix F for equivalent Persian expressions.

[k]) See Appendix F for equivalent Persian expressions.

[l]) See Appendix F for equivalent Persian expressions.

were asked if they needed help. In addition, they thought that if they asked for help, they would not be considered capable people, and so by asking they would lose their honor and face (*az dast daadan etebaar, khejaalat keshidan, hefze aaberoo, hefze hoviyat kardan*[m]).

> **Sharaareh**: We don't ask…we are waiting to be asked….to be polite, we always were told to wait until you are asked or try to find a way by yourself.

> **Baabak**: Not only that, I am too shy to ask for help. I am afraid other Iranians might see me and gossip about me, you know. I would be in big trouble. I was so scared that people might know about my health condition. I felt uncomfortable telling somebody about my health concerns and possible health issues. I found it hard to bring this topic up and discuss it with my friends. I look at it as a cultural taboo. People who are in Canada for a long time and consider themselves open-minded and westernized are not bound to any culture, especially Iranian culture. They are not aware of their cultural ties, but others can tell how different they are from the mainstream. If you are not Iranian, you can see how different they are from the main stream, although they deny it. I felt alone, hopeless and helpless and wanted to attempt to commit suicide so that nobody would know my life story.

One participant talked about her experience and how she was able to overcome shame, but there are still times when she simply cannot forget it.

> **Baabak**: Well, in my case, as a person who slept with prostitutes, I was adamant about seeking services from Canadians and Iranians. I was afraid of sharing my problem with my case manager. I thought that if I were positive for HIV or any sexually transmitted disease, I would be deported to Iran. If I were deported to Iran, I would be arrested and killed because of my political background. I also was afraid of sharing with Iranians because I would lose face and my good reputation in the community.

When it comes to gynecological problems, Iranians do not discuss them openly with others such as friends or children. Seeing male doctors does not seem to be an

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[m]) See Appendix F for equivalent Persian expressions.

important issue, but female participants indicated that they do not accept male interpreters.

> **Saayeh**: Well, they told the hospital personnel, who found a male interpreter for me. I refused to have him. I wasn't comfortable talking about my genital issues and my past with a guy from my community who was not a doctor. I don't mind having a male gynecologist, but in any circumstances I don't talk about my genital area with a guy from my community.

When language and culture are shared, patients and interpreters can communicate very well and patient advocacy becomes possible. Interpreters become a bridge between patients, health care providers and health care services.

> **Saayeh**: Whenever the doctor asked me something and I nodded "No" she thought that was a "Yes," and Mrs. L always corrected it (because she knew about me). The doctor was confused in my "yes" and "no" response. For showing yes and no, we shake our head up and down but people here, for yes they shake their head up and down and for no just move their heads horizontally ___ like this ___ (laughing).

Cultural sensitivity is more than providing services in languages other than English. It requires that the rules of any given culture are also understood.

> **Simaa**: I cannot see culture as a real barrier, because Canada is a multicultural society and everybody is proud of his/her heritage. If you ask a group of people, "Are you Canadian?" they will tell you who is Canadian?...Yeah...they are 3rd ...4th...generation, the bottom line is, their great-grandparents immigrated to Canada. I like this attribute of Canada and I am proud of being Iranian and know lots about other cultures and Caucasians too. I can see problem arise when health care providers or clients are ethnocentric and cannot see beyond their truth.

Time orientation.

Because Iranians are oriented toward the past rather than the present and it is acceptable to be late by about 15 to 30 minutes, they sometimes arrive a bit late and do

not even consider it late. In Western culture, on the other hand, being late is unacceptable and is a sign of being irresponsible.

> **Nasrin**: The nurse at the clinic was very rude to me. I was about half an hour late and she said I missed my appointment. I tried to convince her that I got there by bus and I couldn't make it....she didn't accept it and she said that next time I should get there on time or half an hour sooner...I did the next day...I asked my friend to stay with my kids and I went to the clinic exactly half an hour earlier.... But I could see a doctor only 3 hours after my appointment. I couldn't understand that she made such a case for me because I was half an hour late, but I didn't have any power to ask her to see me on time....it was frustrating. Because I could manage to take an hour leave from my job, ask my friend to stay with my kids, and ask for a taxi to take me there on time...but after all these efforts I was sitting there waiting.

This study shows that immigrants who have language barriers and cultural differences do not get the care that is available and accessible to others, because they do not know what is available to them, how to access it, or how to overcome language, financial, cultural, or time-related barriers to health care services. They rely mostly on information spread by word of mouth that sometimes is misleading and makes the situation more complex and even harmful to their health.

Stage 3: Navigating (Transition Point)

This stage consisted of three phases: realizing the need to know, discovering the differences in the health care system, and searching for resources.

Phase 1: Realizing the Need to Know

After facing health problems or being in need, participants started looking for information and asking for help.

> **Ahmad**: I was trying to find some information. I didn't want to communicate with Iranians, because if you say hi to them, you have to tell them what you are doing in here, and what you want to do...and personal stuff. I went to the library, well I couldn't speak very well but the librarian was very patient and I had a bilingual dictionary. She learned that I wanted

> to see a doctor and had no idea what I was supposed to do. So, she gave me lots of information. She gave me some phone numbers through which I got connected to the interpreter services.

> **Parviz**: I looked in the phone book to find a doctor who his/her surname or his/her name was like an Iranian's or Afghani's. I found nothing....Well it was hard to find...I talked to a friend who was here about 10 years and he was teaching at the university. He was great. He helped me a lot and took my hand and explained everything step by step and then he showed me how I can get information from the Internet on the Canada Health web page.

Individuals who had access to the Internet and were proficient in English could seek information through reliable resources. This group of people was a reliable resource for immigrants who did not know the language and did not know how the Canadian health care system worked.

> **Saayeh**: Whenever I have a problem I try to get some information and educate myself. I read books or search the Internet. There are lots of Persian sites or English ones that help you to know better about your problem. Then you don't ask your doctor stupid questions or you don't look stupid. In addition when you show that you have some knowledge and ask good questions, they are more attentive and start a smart conversation. You feel good because you are respected and you have some power in the situation. I mean you and the doctor have somehow the same power in communication.

> **Simaa**: Well, I didn't have any problem understanding the language and I was capable of using the computer. I went to the Health Canada web page and tried to find what to do and where to start. I got the list of doctors, their contact numbers and their addresses. Then, I called and tried to find the best match. Gee, I like it in here. You can get all the information you need in a second. They are very organized.

Phase 2: Recognizing the Differences in the Health Care System

After facing reality and trying to find information and get help, participants found that the Canadian health care system was very different from the health care system in Iran. In Iran, there are public, semiprivate, and private services, and there are varieties of

health insurance plans. The "family doctor" concept does not exist in Iran. Patients in Iran have access to many doctors and specialists, and they have many choices. They are encouraged to shop around for the doctor they want. Patients normally choose a different specialist for every different complaint recognized by them or diagnosed by another doctor. Thus, it takes time for them to understand that in Canada, this is not an option; they cannot walk off the street into a specialist's office. In addition, the meaning of referral in Iran is different from the meaning in Canada. In Iran, a specialist usually refers a patient to another specialist, but this referral is just an offer. Patients are free to accept the referral or to shop around for another doctor or specialist. Patients can have all their documents and can show the whole process and decision made to the new physicians. The health care system in Iran caters to patients. If they do not like or agree with their doctor, treatment, or his/her diagnosis, they can change their doctor easily, with no questions asked. In addition, they know how the system works, how to negotiate it, and to whom to refer. They are very careful to find connections and prefer informal ones, as they can keep them private. Patients are very open to their doctors and trust them. They believe that physicians are God's hands. They might disagree with their treatment, but they trust physicians to the point that they will give them information about their personal and private life.

> **Sharaareh**: Doctors are just interested in your illness , that's it…Your meaning to them is just through your disease rather than being a human being who is in need. When I think I am as important as the germs in my body I feel very devalued and I cannot get it…I always say what's this…In Iran doctors listen to you and ask about your family. They consider you as a whole, they look at the whole picture, and they listen to your life story. Although in Iran there are some physicians who are the same as doctors here, over there we have the right to choose. Sometimes you know that they behave like this but you know they are the best in the country. It's worth it. Here you don't have the choice…you get these

> doctors without having any idea about their behaviour or the level of their practice…it is really overwhelming.

Although Iranians are familiar with Western medicine and follow physicians' treatments for minor health problems, such as colds, premenstrual pain, migraines, muscle pain, and the like, they might also use some alternative treatments and medicine, such as herbs and homeopathy.

Participants became aware that in Canada their family physicians were the main point of entry into the health care system and that, if they wanted referrals to specialists, they had to obtain this referral from the family physician. At first, they felt that they had lost the power to make decisions concerning their bodies. They found that they could not negotiate as they did in Iran. Because they did not know anything about their physicians, they lost their trust in the health care services. Participants stated that they found it difficult to trust (*etemaad kardan, ghaboul kardan*[n]) physicians whom they did not know. Thus, some of them ignored their health problems or tried to use medication that they had brought from Iran. They did not use herbal medications available in Canada because they were expensive and, again, they could not trust things that they did not know anything about.

> **Tinaa**: I don't like it here. It seems your family physician has the right to make all decisions on your behalf…yeah…they discuss the situation with you but they don't give you lots of choices…there is no room for negotiation…"You are caught between a rock and a hard place…no room to make any different move….. You have to go with your family physician's suggestions. By the time you are waiting for a specialist, you cannot get any special treatments…different treatments or something to relieve pain or other symptom. I didn't know where I could get extra help. I was so upset and frustrated, nobody understood me. I lost my trust in Canadian health care services…yeah if you are in hospital there is lots of help and services are wonderful, but in the clinics they are awful.

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[n]) See Appendix F for equivalent Persian expressions.

Shaadi: I needed to see a gynecologist. A friend of mine said Dr…is a very good doctor and I suggest you got him. I asked my friend to call his office to see if they accepted new patients. His secretary said that they accepted new patients but I had to ask my GP to refer me to him. When I asked my doctor she said, "I referred you to Dr…" My English was not good enough for me to make my point. Well, I didn't like the gynecologist at all. She was very pushy and always told me..."Do you understand?" She thought I was a retarded person. I lost all trust and interest towards Canadian health care services, But what I could do? ...Nothing, just accept it.

Ghazaaleh: I told my doctor that I wanted to choose my specialist but she didn't listen to me. Well, I didn't go there. In fact, I changed family physicians. Well there was no point having her. She didn't listen to me; she had always something more important to think about. I went to a walk-in clinic and from there they sent me to another specialist. Since then I do the same. Well, I guess it is my body and I have the right to choose a doctor. But it is impossible in this country. So I just go to a walk-in clinic because I know none of physicians and there is no point in having one. I don't really like this situation in Canada. But what we can do? We don't have any voice and nobody advocates for our rights…well I accept as it is and don't ask for more or anything different.

Phase 3: Searching for Resources

After they had learned about the differences between health care services in Canada and in Iran, participants started searching for resources. Participants who had language barriers used families, relatives, friends, and people who could speak Persian (Farsi). In searching for insider resources, some came across people who gave them wrong or incorrect information and created more problems, or were not helpful. As a result, these participants were not satisfied and became upset. Because of language barriers and their not knowing enough about health care services, they kept switching from one person to another. This group of people liked to have health care providers from the same country or who spoke the same language as they did. They were looking for Iranian physicians and health care providers and felt more comfortable about getting

help from them.

> **Payaam**: At first, I tried to deal with the situation by myself. I sat for hours and couldn't find an answer to my question "where can I get help?" Well, I had a friend who has lived here for a good 5 years. But ___ well, I didn't like to share my situations with him and ask him what to do or where to go. You know__ I had difficulty with the language and I had some financial burdens. He knew that while I was in Iran I had a very good job and position. I thought I was going to lose my identity and my face in front of him, and he would not rely on me and my other abilities because of this. Anyway…by sitting and thinking I got nowhere, I said whatever the result is going to be, I have to call him and start from somewhere. I called him, but to my amazement, he said he didn't know what I had to do…he said "I have a friend you can call her and ask her." Well, at first I said "no," because___ I didn't want to be the center of everybody's discussion. As a result I lost my trust in Iranians. I tried to communicate with a guy from Afghanistan, and we could understand each other's language. He helped me a lot, and he introduced Ms. F, who works with Iranian and Afghani newcomers in Edmonton.

> **Parviz**: The first thing that struck my mind was calling a friend and asking him what to do. Well it wasn't a great help. He was saying that___ well, I don't know…It didn't happened to me…I tried to use those meds that I brought from Iran for relieving my chest pain. I thought that the chest pain was because of flu or things like that. I never thought of heart problem. Well….It was one and half years after my screening test to come to Canada and we don't have a family history of heart problem especially at a young age. Anyway by taking those anti-inflammatory and pain killers I could survive till…BANG…I experienced such an intolerable pain in my chest and was transferred to the ICU and was there for 2 weeks due to unstable angina.

> **Aarash**: There are many Iranian TV channels in the USA and they are in the Persian language. Many practicing physicians who are specialists in the USA have live programs. I call them and talk to them and they answer your questions and help you know what is better to do and how to deal with your doctors in North America. They explain for us how things work here and what we have to do. Unfortunately, we don't have such a thing in Alberta. We all depend on Persian channels in the USA.

Although some participants had language barriers, they chose outside resources because of their experiences with Iranians both in and outside of Iran.

> **Saayeh**: She [the landlady] asked me "have you picked a family doctor yet?" I said "no." She said "you had better pick one." I told her "I don't know how…I don't know any doctors in Canada…how can I choose when I don't have any idea…how can I trust them since I don't know them"...in Iran it is different…you try to get lots of information…I mean…as much as we can from friends family and relatives…try to find the well known and experienced doctor, but here how I can do it…I have no friends and relatives…so…moreover in Iran we don't have family doctors. We choose the specialist by ourselves based on our information, their availability, and the severity of the illness. She said, "I like my family doctor, she is very caring. Would you like me to call and see if she accepts new patients? We can go and visit her. If you don't like her, we will try another one. Don't worry I'll do my best to hook you up with a good doctor."

She added that:

> …Well, it is a little bit funny. Again, I talked to my landlady. She knew I was in the hospital and she was with me when I got discharged. She explained everything to me and she was more helpful than the interpreter. I learned two important lessons. As I knew that I wanted to live in this country for the rest of my life, I told myself…"Hey, you should start from zero and it needs a great deal of effort."

Some participants used insider resources (Iranians), some used outsider resources (Canadians, Canadian organizations and facilities), and some went back and forth between outside and inside resources. They felt satisfied if they got good support and help but became upset and even ignored their problems when they did not get enough support and help. Those participants who did not have language and communication barriers usually used outside resources and were satisfied with the services provided.

> **Simaa**: I get help through the Media, friends, and librarians. To tell you the truth librarians are doing a fantastic job and nobody seems to be familiar with their job. I always tell my Iranian friends who ask me questions. "Go to the library and ask them…they are such wonderful sources."

Stage 4: Employing Strategies: The Journey of Going Through

(Turning Point)

This stage consisted of two phases. Phase one included weighing options and dealing with barriers, whereas phase two related to evaluating outcomes.

Phase 1: Weighing Options and Dealing with Barriers

(Turning the/a Key)

After recognizing the differences in health care service provision in Canada, and facing problems and barriers, participants moved to the next step of weighing options and dealing with barriers. Individuals who did not have any previous experience with health care systems in other countries and who had language barriers found this phase much more difficult than those who had previous experience or who experienced no language barrier. Some individuals found it so hard that they turned back to the previous stage (Navigating) and started from there again, being trapped in a loop. This group of people could handle some of their health issues but were never satisfied and had to ignore some of their problems. Some even turned away completely, disconnected themselves from Canadian health care services, and reconnected to the health care services in Iran.

> **Ghazaaleh**: I never could make it. There is always something that stops you. There are lots of barriers. You solve the first, you face the next…Well, I tried to get help from friends and always go back to them and use different ways, but always it seems there is something that makes you feel handicapped. You never win. It is kind of going back and forth. It is frustrating but you get used to it.

> **Saayeh**: I needed time to think what I should do and who I should consult with…I knew nothing…I ended up at nothing. Then we went home. I told myself it is just a simple cold and doesn't need a particular treatment. It is better to cook healthy and comfort food for them and make them drink lots of fluid.

Sharaareh: Well, I prefer to use drugs that I brought with me rather than going to see a physician here. You have to wait for a good 3-4 hours to see a doctor. It is terrible. Last year, I went to see a doctor for a yearly check up. I waited there for a good 4 hours. I got a terrible cold from other patients. It was funny. I was healthy and wanted to have a check up but I ended up getting really sick. Well, for things like that I will never ever go to the doctor's office again.

Saayeh: I didn't know…didn't know who to visit….At that moment I was trapped…I couldn't even speak in Persian let alone in English. All of a sudden, an idea struck me. I told myself…Yeah … I know what to do. I took the kids to Emergency at the hospital. In ER they won't ask me lots of questions and they will help us very fast…___ you know because I knew about ER and how quick they are in Iran…in Iran they took care very fast…____. Therefore I asked for a taxi to take us to ER. In the ER we were waiting for long time but they didn't ask me lots of questions….They asked some routine questions and somehow I could manage it. It wasn't as stressful as it was in the clinic. While we were waiting there, unfortunately, my little daughter had a seizure, and the doctor told me she was very lucky. He said if I brought her to the ER a bit later, she would have ended up being an epileptic kid. When he told me how serious we have to be about fever, especially in kids, I changed my mind. I told myself "be strong" "make yourself ready to cope with hard situations" "ignore people and what they think about you."

Sometimes, participants found the services they required in other countries. Often it was trial and error for them. They tried to get help from Iran or asked for help from their family and friends in other countries.

Saayeh: Right away, I called Iran, and I told my mom about the kids' fever. My mom said "don't waste your time and ask a doctor to treat them." I didn't know what to do; I didn't how to start from the beginning again. I was hopeless, helpless…I was stuck in a painful situation…I couldn't make up my mind; I was caught between the devil and deep blue sea. I start giving them a foot-bath, feeding them soup, tea and aspirin. I tried to escape from reality; I didn't want to accept the reality and tried to deceive myself. I thought I should be strong and be patient.

Shaadi: I called a friend who lives in the Netherlands. I told him that I am in real trouble and it seems that nobody is going to help me. I asked him what to do. He said that his brother-in-law was a very well known

physician in Tehran. He called him and set up a time for us to talk to each other. Doctor X said he couldn't make any diagnosis without having any clinical report and examination. He said go to the emergency to get some help and then tell me what they said and from that point I would help you and I would send your medications through friends. But first go and get some help and don't waste your time.

Tinaa: I brought all the medication I needed for at least 2 years with me. I knew I would have no money to buy any medication. Before coming to Canada I heard that medication is very expensive in Canada and it is impossible to afford it.

Sharaareh: When my friends learned that we are leaving Iran, all of them who are outside of Iran, especially in Canada, suggested to me to bring all needed medications with me and some of them even gave me a list and told me to bring them in Canada for my family and for them too….I got the real message…and the message was don't even bother to ask for treatment.

Shaadi: If my problem was not very critical, I called my family in Iran and consulted with them and asked them what was better to do, or asked them to consult with my cousin who is a doctor in Iran and even asked them to send me some pills for my health problem. For example, I always used one kind of oral contraceptive. I tried many different kinds when I was in Iran. None of them was good. I always experienced spotting. One type works very well. My family send it to me. I am not going to change it.

Nasrin: I called to my brother in Iran. He is a pharmacist. I told him about this medication and he said don't be afraid of taking it. All medications have some sort of side effects. It is just for your information. He asked about its price. It was very expensive in here and I had to take it for at least 6 months. He said don't buy it again. He sent the rest for me and it was way much cheaper and I could read all the important and must-know information in Persian. I was so happy and satisfied with my medication and treatment, but I didn't tell my doctor what I had done. Because if I told him that I am taking a medication with the same effect with different name he would tell me "no don't take it."

Mahnaaz: Every year, my family sends me some pills for headache, muscle ache, fever, cold and diarrhea and also some routine antibiotics.

Therefore, I can manage some common health problems without being in lots of stress to make an appointment to see a doctor and stay in a long waiting list.

Payaam: My wife's English is better than mine. I mean she can understand medical terms. She was a newly graduated physician from university. I always asked her to be with me when I was seeing a doctor. At least she could explain the situation for me. She was a big help in everything. We came here as refugees. I knew English a bit but I never used it seriously in Iran and I didn't have any plan to be out of Iran. I was really dependent on her, but I preferred to be dependent on her rather than anybody else. At least we didn't have problem to match our time (laughter). She helped me a lot in learning English.

Mahnaaz: Before going to the doctor, I call my friend in Iran. She is a doctor, a very good doctor. She assesses me and helps me to understand the situation better and helps me to ask good questions. I am lucky to have her.

Some individuals without exposure to health care services in other countries happened to meet people here who were comfortable with the Canadian health care system. These individuals served as guides or role models, and helped the new Iranian immigrants obtain the services they required.

Saayeh: This time, I mean my second experience at the doctor's clinic was totally different from my first experience. Having Mrs. L beside me who knew me and was familiar with my situation was such a big relief, put me at ease and gave me lots of self-confidence. At this time, I could answer almost all of her questions. She was so patient and she spent a lot of time with me.

Nasrin: I had a very close friend and I told her my problem. She has been in Canada for more than 10 years and she was in England for 3 years. She speaks English very well. She called the clinic, the same clinic that she goes to for herself. She made an appointment for me and she said "I will come with you, don't worry." She took one hour off from her job and we went to the clinic. Oh boy, she was such a great help. Many times she did it for me. But I was kind of uncomfortable. I felt guilty because she has to spend lots of hours for me and for some questions…you know although she was my friend….Best friend…But still there were a few things that I

didn't like to share with her. They were very sensitive questions and I got stuck between a rock and a hard place…I didn't want to talk about those things and lose face in front of my friend. I always didn't answer those questions or didn't tell the truth. Actually these situations encouraged me to learn English and be really independent and also keep my friendship up to now.

Pari: Then the doctor said that she could understand how hard it is to be an immigrant. She said that she still remembers her family's suffering, and it was hard for her and her parents when they immigrated to Canada many years ago. I guess that's why she was so caring, patient, and different and spent lots of time with us. Later on I didn't have any problem making an appointment and going to her office. I felt so comfortable with her, no anxiety whatsoever. I knew if she didn't understand me she would spend time to get it right. Little by little, as time passed, I got enough strength to handle stressful events better than before.

A third group of participants without exposure to health care services in other countries did not want to learn English and tried to find Iranian doctors. They wanted to speak Persian in Canada and to relate to their Canadian physician in a manner that was consistent with the patient-physician relationship in Iran.

Shaadi: Well, I asked one Iranian doctor to give some samples to my sister who didn't have money to pay for health insurance but he refused. It was shocking to me. I said "you know some Iranians' situation if you don't care about us, how could it be possible to ask others to be sincere to us." I was so upset and I chose another family doctor. I didn't ask for anything from the new physician. I was like "ok, what I can I do for my sister"…Then I called my cousin who is living in Iran and asked her to go to the pharmacy and explain the situation to the pharmacist and ask him what kind of medication is good for her. She had pain in her joints (arthritis). Well he suggested some pain killer which my cousin bought then sent to us. It worked very well. She was happy with this but after 2 years she got such big problem with her stomach…kind of wounds? Bleeding….she went through disaster…lots of tests and she was even in hospital for 3 weeks. I guess it all goes back to the Iranian doctor…he was mean...if he helped my sister and gave her some pills my sister wouldn't have gone through these problems after problems…I never forgave him and I don't have any respect for him.

> **Mahnaaz**: I had high blood pressure when I came to Canada. I have had this problem for 15 years. It was not new to me. I brought some pills with me and when they were used up and I didn't have any pills, I went to a family physician and told her my problem. She prescribed another type of medication. I asked to have the same medications because it worked for me and my blood pressure was under control. She said "I am your doctor and I suggest this." Well, I asked the pharmacy (of course with broken English) to tell me more about this medication and the difference between my previous medication and the new one. He got so nervous and treated me like a criminal, accusing me of killing myself and so on. I got so upset. I cried all day. I took the new medication and my body didn't take it. My blood pressure dropped and I collapsed. I was in hospital and I tried to explain what happened to me. I collapsed because of this new medication but they all stressed my behavior. I was helpless. It was too much. They tried to fix my blood pressure. While I was in hospital I cried a lot. I was lucky because the resident was Iranian and I told him my entire story and he fixed the problem. I got the medication but of course with a different name but the same action. My blood pressure got fixed and I was so happy. I realized how important it is to have somebody to advocate your case when you have no power or unequal power in the system.

Having an Iranian doctors was not always a satisfactory experience. One participant who was a physician in Iran and currently working with a physician felt that some Iranian patients had unrealistic demands and expectation of Iranian doctors just because they were Iranians and to her it was kind of abusing the services and system rather getting help.

> **Simin**: Sometimes they ask us [health care professionals] to do something that is not acceptable and does not fit with Canadian health care services. For instance, they do not have insurance coverage but they don't want to pay for their visit. They ask me to treat them for free and not report it. I tell them money is not important for me when comes to you as a patient who are in need, but I have to report it. They think I am the anti-nation person who has lost his love for the people from his country. They go on and on and tell everybody he is not a good doctor and he has forgotten that he is Iranian. Well, what can I do about this, just tolerate this situation and say that I understand you, but sorry…I cannot do anything for you and this is the way it is here. You know, they should come to this and understand that every country has its own way of doing things and you cannot apply your way of doing things to their ways. They should learn how things work here.

Some participants mentioned that because of less paper work and the same waiting time, they preferred to go to hospital emergency departments, even if their problems were not urgent. They said that it was very convenient for them to drop by to the emergency department any time especially in the evening or late at night, and they did not have to take leave from their job. As well, this meant that they were not under pressure to find someone to take care of their children, as their wives/husbands or their neighbors were available to give them a hand. In addition, they could get their medication free from the department.

> **Mahnaaz**: I had appendicitis and it was hurting. I went to the medical center and the physician asked me to go for blood work. It was late. My kids were alone, and I had to do it the next day. But the pain got worse and worse and I said I cannot wait till tomorrow to do the blood work and wait again to visit a doctor. I went to ER. Although there was a long line I liked it more than the medi-centre. They are more practical. At the medi-center, each time they assigned you to a new physician. I didn't like it but I had no choice. If every time I am going to be visited by different physicians and have lots of paper work…I go to the ER…less paper work and they give the meds that you need.

One participant mentioned that having a doctor who understands immigrants' situations is important. Physicians who are immigrants understand immigrants better and spend more time with them to fix their problems.

> **Pari**: You know, we like him. Although we moved to another apartment far from the medi center, we didn't switch our medi center because of him. Since he moved to another medi center, we followed him…[laugh]…No matter how far he goes we just follow him…Because…because, he spends time with his clients, I am really comfortable with him…he is not Iranian, but he is an immigrant from one of the African countries…. Well, he understands us, and as soon as you know that he has experienced the same things, you feel more comfortable sharing your unhappiness and your issues. For example, when you are looking for a word and you cannot find it, he helps you. Therefore, you are not embarrassed about your broken English or your accent, and he has an accent too. This is my feeling. It might be true or might be wrong, but it is how it goes with me…In addition, when you are stuck in a very emotional situation…like an

> emergency situation…you might have trouble finding words in your mother tongue, and your mind goes blank…let alone another language. In this situation, in your mother tongue, your vocabulary is rich enough that you can convey your message by using another word and a different style, or by using common and shared body language, which is not going to happen here. This situation…this struggle….is one of the worst situations for immigrants who suffer from a language barrier. At least, this is how I feel, and it is my experience.

Phase 2: Evaluating Outcomes

Participants who could not master English became stuck in a loop of going back and forth; these individuals were dissatisfied, felt marginalized, and perceived experience of discrimination. They lost their trust in Canadian health care services. Participants perceived being discriminated against and being marginalized while being treated by physicians. They mentioned that misunderstanding, miscommunication, lack of cultural knowledge, and the physicians' self-centeredness could be considered reasons for discrimination and marginalization. Therefore, they put off visiting physicians or following their recommendations, or got help from informal resources. By doing so, some ended up in critical situations. Some individuals mentioned that mismanagement and the provision of inappropriate resources resulted in patient dissatisfaction and perception of being discriminated against.

> **Tinaa**: The stronger your accent and the darker you are, the more discrimination you will experience in obtaining health care services.

> **Payaam**: After my experience with physicians here and seeing all these misunderstandings, miscommunication, and ignorance I lost all my trust in physicians here. When I went to Iran to visit my family, I chose a doctor and I told him my story and I asked him to be my family physician. I always call him and ask his opinions and from time to time I ask my family to send me some medications. It works for me. I like it and I don't bother myself to go to a doctor here even for a routine check up. I do it when I go to Iran or through calling my doctor in Iran. If something very serious happens here, for sure I ask for help but for now…thank you...I

don't accept any care here. It doesn't work for me. I am happy with my way of handling my life and my health issues.

Aarash: What bothered me a lot when I was hospitalized was that some personnel were very selective and gave their favorite patients better service.

Tinaa: When you have a knowledgeable translator you can see the differences. There is a problem here. First of all you don't know them. I am talking about Iranian translators. I happened to use two of them. One was not helpful at all. Her English was not good either. Another one was a young lady, and she had a good knowledge of English and Persian…and was very kind and very professional, which was really helpful. I trusted her because of her personality. The problem is…well…you cannot choose your translator. It is kind of assigned by the interpretation center. In addition, the center doesn't provide a fulltime translator the same as for other nationalities. I call it discrimination. We are living in the same country and the same province. All of us have the same problem, "language"…right? How come some can get more services and other are left out? We keep getting confused with Afghans and Arabs. In some facilities, you can even see materials and forms in another language like Chinese, Filipino or Spanish, but not in our language. It is obvious that something is missing.

Sharaareh: You know when I am in the doctor's office, clinic, or hospital, it means that I am ill and don't feel ok, and health care providers should have at least some sort of understanding. Some health care providers don't even welcome clients whose appearances are not presentable. I don't like to mention the name of the doctor's office and his nurse, but oh, my God, employees over there are terrible. Yeah, they are like that to many people, but if somebody doesn't have a language barrier and knows that it is her/his right to be treated professionally, they stand up for themselves and tell them that their behaviors are not right and they shouldn't behave like that. But I don't know how to express my feelings so as not to appear rude, and I don't know how to express my feelings. I feel that some health care providers should change their behavior and treat patients with understanding and compassion.

Payaam: I don't like it here. As soon as you open your mouth and speak with an accent, they start asking where are you from and right away about political turmoil in my country…the center of conversation always changes from my situation…my problems to my previous country…It is really annoying…it is too much…you know they are masters in asking

questions and getting all the information they want to know while approaching softly…the way that you cannot tell them and you don't want to be considered rude…but I didn't know how to tell them "you know what ? I don't want to talk about the things that I am not interested in…please stop it…I am not here to satisfy your curiosity. I am here because I am in need and I am sick"…even you have lived here for 15 years you still feel that they don't consider you one of them…the way they approach you and the like…to me it is not fair and against the code of discrimination…like it or not, believe or not…it is my feeling. I am tired of saying that I am from Iran and answering questions about how things are going on over there. I wish there was a way to ask the government to stop people from behaving like this.

Nasrin: I believe that cultural differences and language barriers are important issues. But…but...Ummm…let's look at this from a different angle. Doctors treat people that are unconscious and cannot talk. Doctors try to spend lots of time and go through patients' files many times to make the best decisions. Usually they are successful…how could it be possible to cry over differences and blame language barriers for doctors not making enough effort to treat people. To me sometimes it just an excuse to bar immigrants from health care services…who cares? Who is going to find out about this ignorance? Nobody…yeah language barriers make patients hesitate to be assertive about their rights and debate over it. This is the thing I call discrimination…yeah discrimination…well not really…let's put it this way…hidden or instinctive discrimination.

However, many participants stated that time helped them a lot to recognize their issues, manage going through the system, and overcome their shortcomings.

Simaa: Little by little…gradually, by facing some problems, we learn that we should take this information into account seriously, and we come to understand that some papers are really important and should be read, and if it says for more information call or contact us at this number without any hesitation, it means it. The rest is up to us…I mean it is our responsibility to read and follow the directions…it is our job to ask if there are any questions or if we need more information…nobody can read between the lines…they cannot read our minds…if we don't ask, we are not going to get any help…It is different from Iran…In our culture…it is not good behavior to ask….We always have been told. You know…if we follow instructions and read them carefully, life is going to much easier for us, for people around us, and for people who want to help us.

Shaadi: At first I was very hesitant, but as time went by I learned that if I don't ask, nobody will know what I need, and if you ask for help or some

> information, it doesn't mean that you are not able to take care of yourself. I learned to talk about my concerns. Nobody told me. I found out through experience, which was a long time and energy-consuming process. If I had been told that I should talk about my needs without being hesitant or being afraid of getting deported, I wouldn't have had this many problems with getting health care services and I wouldn't have had this much hassle and probably would be more satisfied. I don't understand the system sometimes because they keep making referrals and I get tired of calling these agencies.
>
> **Nasrin**: From that moment I made a decision to learn English to be able to make my point and to have an active role in making any decisions about my body or my life. Although I didn't learn fast because I am not young, I am much better compared to that time. At least I can ask questions without being embarrassed.
>
> **Saayeh**: I registered for an English course and started reading newspapers, listening to the radio, and watching TV. If I didn't know, I asked. I learned that people cannot read between the lines. I should open my mouth. I should ask if I have a question. It is my responsibility. I learned how to communicate with Canadians. I tried to find out how Canadians access information. I tried to find what other sources are available and asked if I was in doubt. This way, although it took time and I spent lots of effort and energy, I am happy with its result. One of the best results was to have Canadian friends as one of the most reliable sources of information. My English proficiency improved and I could communicate, share my information with my friends, and get more help. Having support from Canadians is the key.

Over time, participants learned that if they wanted to obtain some health care services, they would have to find a way to trust physicians who were accepting new patients. Because their familiar strategies for developing trust in a physician were not possible in Canada, they developed new strategies when looking for physicians who could communicate well and were willing to spend more time with patients who had special needs due to language barriers, cultural differences, and financial limitations.

> **Pari**: Our doctor in the medi center was a good doctor. We always tried to find out the dates he was working and go for treatments then. He is a really good doctor. He spends lots of time with his clients. He is not just

doing his job like a machine. He communicates with his clients very well. You know, you could count on him.

Ahmad: Well, I came to Canada about 10 years ago, the situation was different…doctors were more approachable and they spent lots of time with patients especially with those that had language barriers.

In this way, Iranian immigrants became able to trust their health care providers in Canada. This trust was built and maintained through experience and over time. Participants who found physicians whom they could trust noted that they were now learning how to manage their new health care problems.

Nasrin: As time went by, I started trusting my doctor. Little by little we got to know each other. She spent more time than usual with me. She is just a fantastic listener. I always carry my bilingual dictionary with me and try to explain my problem to her. I don't ask for an interpreter…I have to do it by myself…Actually my doctor always says that I am doing a good job and my English has progressed a lot. She makes a real effort to understand me and explain things to me. She uses body language and even sometimes she explains my problem and treatment by drawing. I never ever change my doctor…even if I move or she moves I would rather make a long trip to get her. She said that her parents immigrated to Canada years ago and her parents told her how hard life was…so she has lots of respect towards immigrants and understands them.

Stage 5: Becoming Integrated and Self-Sufficient: A Journey towards Integration and Connectedness (Turning Point)

Those who tried to accept differences in provision of health care services in Canada and tried to be active contributors in their life felt comfortable accessing health care services, although many mentioned that it did not mean that Canadian health care services do not suffer from any shortcomings. They stated that they are dealing with health care services in the same way as Canadians, who have the right to stand up for their rights and get services. Generally speaking, they mentioned that they were pleased with Canadian health care services. They believed that family members or friends who

are knowledgeable are great sources of help for linguistically and culturally diverse individuals. They can provide some knowledge of where to go, how to get there, and some details about the Canadian health care services and system. These participants stated that they know how to "turn the corner" and deal with new situations. They mentioned that they are ready to help newcomers, show them how to deal with life in their new country, and help them to gain independence and self-mastery by empowering them rather than helping them all the time and keeping them reliant on others for resources. They pointed out that newcomers need both inside and outside resources and support. In addition, newcomers should be connected to individuals from their communities who are integrated into their host country and can serve as role models.

> **Ahmad**: I appreciate Canadian health care services. I've gotten good care, and I am more than happy to help people who are in need and to use all available services.

> **Simaa**: Actually it took time to get to know how the health care system works in Canada. I lived in Sweden and the UK before coming to Canada. I knew that every country has a different system. Comparing the Canadian health care system with health care in the UK and Sweden, I prefer those in the UK and Sweden. Well, generally speaking, I am satisfied with the Canadian health care system. To be honest with you, I haven't had serious issues with it. I got along with the system and the health care providers very well. My family physician not only treated me well but also introduced other possible options to me. I don't feel there is a barrier for me in the access to services.

> **Simin**: I feel comfortable with the system now and I am ready to help people who are new to this country. I think there is a real need to have more advocacy among health care providers in order to make known that there are different resources available in Edmonton, especially for people who are new to this country and have different experiences regarding health care services or cultural differences, and who suffer from language barriers. I believe that speaking perfect English helps a lot in getting health care services. People with language difficulties are not treated fairly. Some health care providers cannot understand what it means to be

> sick in a country that you don't know much about when you have communication problems.

Those who were dissatisfied with services stated that overall they do not like the Canadian health care system and never felt comfortable using it. They think that there is no Iranian community as such from which they can ask for help or get real support.

> **Tinaa**: I have received health care services for at least 5 years. I am not really satisfied with the health care services, because some providers were not nice to me.

> **Simaa**: Having some sort of community makes a big difference. There is no Iranian community as such; we are not a community yet. There are some Iranian groups, but they are not related to each other. In addition many Iranians are either not aware of the presence of these groups or not interested in being a part of them. My point is that if we Iranians work together and help each other, we can over come difficulties faster and more easily, which is true but—I am sorry—it doesn't work for us. This separation hasn't happened in one night; it has deep roots in our history as a nation. By being immigrants, people don't give up their ideas, beliefs and the things are part of their identity. Their identities are defined by their thoughts, their ideas, and their beliefs.

These individuals were skeptical and unable to trust the services. As time passed, this group of people turned away and did not receive services. They left the country or reconnected to the home country's health care services, or else they turned back and received help from friends in Canada, outside of Canada, and in Iran. In the meantime, if they happened to meet people who are comfortable using Canadian health care services, they tried to follow their suggestions, trusting them and accepting them as role models. Therefore, after a while, they became comfortable using Canadian health care services and took on the role and responsibility to help others.

> **Ahmad**: My attitude towards health care services here (in Canada) is different from the time I arrived in this country. Like day and night…Now, I use health care services like a citizen. I don't have that much problem. I know where to go and if I don't understand I ask them to

explain it. I don't ignore it as I did before. I don't hide my feelings and I speak out. One of my most helpful strategies is to obtain some information—as much as I can—before I actually ask any questions or explain my situation.

Saayeh: Having support from inside and outside of the system and my landlady who without her help I couldn't make it at all.

Simin: Well, there are many ways; asking questions, sharing my needs with friends, and asking them how they usually obtain information. I believe that having some good information is really important and very helpful. It helps us to ask suitable and related questions. It helps us to be calm and not be nervous, know technical words, and give us a chance to have an active role in our treatment, take more responsibility, and be able to negotiate when it is necessary. In this way you sound smart and knowledgeable to health care personnel and they are more eager to help you. You know in this case the pattern of communication is going to be different. It is going to be like a two-way road. There is no superiority or inferiority and the level of satisfaction is really high; both client and health care provider will be satisfied.

Saayeh: For example, as a person from a developing country, when I compare the Canadian health care services with ours, it is obvious that the health care services in our country are very different from the Canadian ones. Having a universal health care plan is one example. Another example is that people pay health insurance based on their income and if they don't make enough money they can ask for an exemption. Having advanced technology is another example. These things are only dreams for people in Iran who are not rich. I think the health care system in Iran is one of the most corrupt systems and everything is based on money. Therefore, I am not going to talk about Iran or compare Iranian health care services with the Canadian ones.

She closed her discussion with this comment:

I think as a Canadian who pays tax and votes, it is my right to be sensitive and work towards a better life for Canadians. Like any citizen, it is my right to fight for a universal care plan and ask for drugs and dental coverage, making waiting lists short, having the right to choose your doctor, and the like. It doesn't matter whether you were born in Canada or somewhere else. Everybody tries to find the most suitable way to cope with the system. Many Canadians do the same. They go to the hospital by themselves or ask a friend to give them a ride rather than asking for an

> ambulance, because they are tired of lots of paperwork and slow services and paying big bucks on the top of that.

These findings showed that in the journey of accessing Canadian health care services, Iranian immigrants went through a process that began with becoming a stranger and ended with becoming self-sufficient. In this transition, they faced many barriers that they had to overcome. It revealed that because of communication/language barriers, many participants did not find Canadian health care services satisfying and trustworthy. Therefore, they delayed treatment and failed to use, misused, or overused resources and services. Tackling the stumbling blocks to access was the main struggle in this journey. Some of them won on this battlefront and became self-sufficient, but some could not make it and stayed in different stages/phases, going back and forth, living in limbo, dissatisfied, and sometimes even becoming disillusioned. This process explains why some Iranian immigrants were able to use Canadian health care services effectively while others could not.

CHAPTER V

TACKLING THE STUMBLING BLOCKS OF ACCESS

In this chapter, I discuss the process that Iranian immigrants experienced in accessing Canadian health care services. The core category of "Tackling the Stumbling Blocks of Access" and the basic social process of " Becoming Self-Sufficient" emerged, as it was present in all five stages of the process of becoming integrated and self-sufficient for all participants who were able to successfully navigate the health care system and get their needs met (Figure 2, p. 126). The first four stages (becoming a stranger, feeling helpless, navigating/seeking information, and employing strategies) will be discussed in this chapter and the last stage (becoming integrated and self-sufficient) will be discussed in following chapter. Each stage except stage five has more than one phase embedded within it. As each stage is presented, a pictorial representation of the stage will be given. This representation will be cumulative, leading to a figure of the model of access to health care that emerged from the findings.

Stage 1: Becoming a Stranger (Starting Point)

People who leave their own country and settle in another country experience transition. They settle in a country that they know little about. Becoming a stranger is the first stage that they go through in their journey. This stage has three phases; ignoring the self (Phase one), getting lost (Phase two) and getting disconnected (Phase three). Everything is new to them. They learn that they have to spend time and energy to become familiar with their new home. Because of the collectiveness valued in their culture, Iranians put the family's needs first and ignore their own needs. As their budget and

Figure 2.The Process of Accessing Health Care Services: Becoming Integrated and Becoming Self-Sufficient

Stage 1: Becoming a Stranger (Starting Point)

* Ignoring the self
* Getting lost
* Getting disconnected

↓

Stage 2: Feeling Helpless (Entry point)

* Becoming in "need" of accessing Health care services
* Facing barriers

↓

Stage 3: Navigating/ Seeking (Transition point)

* Realizing need to know
* Recognizing the differences in the health care systems
* Searching resources

↓

Stage 4: Employing Strategies (Turning Point)

* Weighing options, dealing with barriers, (Turing the/a key)
* Evaluating outcomes

↓

Stage 5: Becoming Integrated and Self-Sufficient (Turning the corner)

financial resources tend to be limited, they find that they are busy, and always try to put themselves and their needs last and consider others, such as their children and spouse, first. These findings are consistent with those of Behjati-Sabet (1990), Behjati-Sabet and Chambers (2005), Dossa (2004a, 2004b), Remennick (2003), and Shahideh (2004). Congruent with literature, three participants in this study stated that based on their culture, although they were not healthy, they ignored and hid their needs. I called this starting point Becoming a Stranger. In their journey toward becoming self-sufficient and integrated, all participants started at this stage, although they moved along their later path differently. Analysis of the data from this study showed that almost all Iranians in the first stage of transition felt like strangers: lost, confused, and disconnected from the new world (Figure 3, p. 128).

Participants mentioned that while going through this phase, they experienced feeling helpless and hopeless. Individuals became disconnected in many ways; geographically, physically, emotionally, and the like. They had little sense of themselves in relation to the new country. They felt incapable of doing things and of learning new things. They felt that they were not capable of managing their families, which affected their sense of identity. Two participants shared their feelings in this regard by telling me their stories.

As Lipson and Meleis (1985) have pointed out, "Immigrants often experience a degree of loss of familiar ways, familiar meanings, and particularly, the social network on which they previously depended" (p. 49). All participants mentioned that they experienced disconnectedness. A few could not handle it, became disillusioned, and left Canada (Figure 4, p.129). Changing roles, losing possessions, having different networks

Figure 3. Stage One: Becoming a stranger (Starting Point)

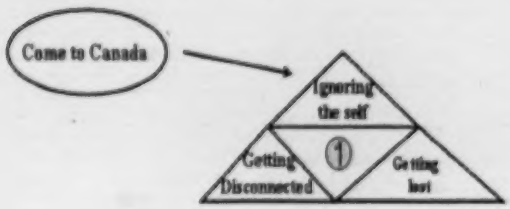
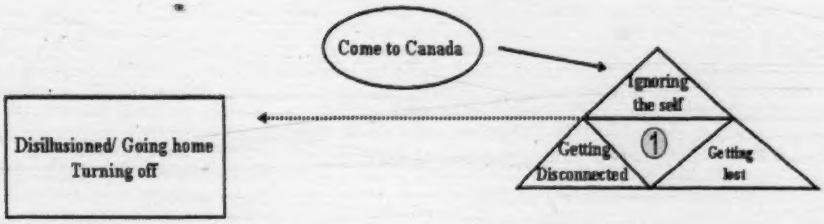


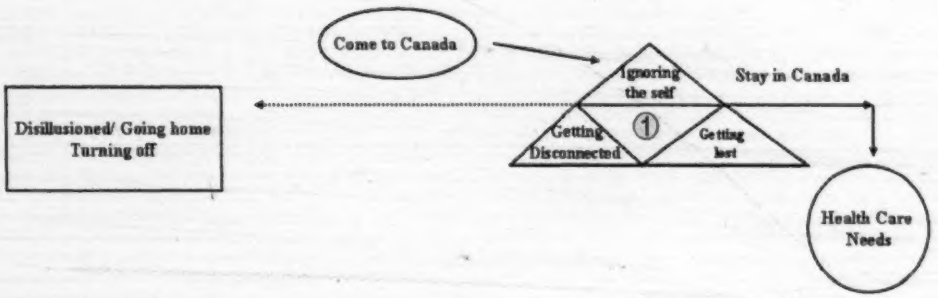
Figure 4. Became disillusioned



for making decisions, and losing meaningful attachment are important stressors that affect immigrants' health directly. Disconnectedness affects the whole being, separating the individual from home, from the past, and from the family (Behjati-Sabet, 1990; Behjati-Sabet & Chambers, 2005; May, 1992; Schumacher & Meleis, 1994; Stevens et al., 1992; Sullivan, 2001; Williams & Berry, 1991). Their job, their status, and even their human relationships are subject to change. Most important, the language they use every day is not there anymore. Therefore, both physically and symbolically, everything that they construct their world with is transformed (Behjati-Sabet & Chambers, 2005; Sullivan, 2001). This can be seen in most participants' interviews. They mentioned that they did not know what to do, or to whom to speak.

Behjati-Sabet and Chambers (2005) mentioned that those Iranians who have unrealistically high expectations about Canada become disappointed and return home after a few months or years in Canada. They added that those who have to remain in Canada do so out of a sense of pride. In support of this perspective, one participant stated that immigrants experience hard times and that his friends who could not "make it" left after two years in Canada. Those who went back (turning off) to Iran became reconnected there. Although immigrants are young, they are not in their twenties. They were settled and they had jobs in Iran. They stated that it is not easy to learn new things. As a result, some of them could not face the reality and returned to Iran. Some of those who cannot or do not want to turn back to Iran because of their political or religious background stay in Canada. Eventually, they need to use health care services (Figure 5, p. 131). At this point, they move to the next stage (Stage two).

Figure 5. Becoming in need of accessing health care services



Stage 2: Feeling Helpless in Accessing Health Care Services and Facing Barriers

Canada has a prestigious reputation for providing publicly funded health care and for providing equal and timely access to services based on individuals' needs rather than on status, wealth, or any other privileges. Although the Canadian health care system needs to be revisited in some areas, according to Romanow (2002), it is one of the best in the world, and the majority of Canadians are satisfied with the care they receive. My findings showed, however, that immigrants still face some structural and nonstructural barriers that prevent them from accessing the services that they need.

In this stage (Figure 6, p. 133) along with feeling strange, being disconnected, and not knowing the language, they had to get help to use health care services (Phase one). They faced many challenges and barriers (Phase two), both structural and nonstructural, while accessing health care services in Canada that were different from those in Iran. Dealing with barriers was very frustrating for some of them and they returned to Iran (disillusioned) (Figure 7, p. 134). Of those who stayed, some felt helpless and frustrated, and became isolated (holding on) (Figure 7, p. 134). They lost their support networks, possessions, and meaningful attachments, which compromised their physical and mental health (Stevens et al., 1992; Sullivan, 2001). Individuals can understand each other only through interconnectedness with one another, regardless of race, color, religion, or ethnicity. Learning happens in a relationship with others, not in isolation (Shadideh, 2004). Disconnectedness from history, belonging, and culture and lack of interconnectedness or reconnectedness can lead to a major collapse. The feelings of strangeness and lack of belonging contribute to a greater level of disconnectedness from community (Ricoeur, 1992). From those who had to remain in Canada, some stayed

Figure 6. Feeling Helpless in Accessing Health Care Services and Facing Barriers (Stage 2)

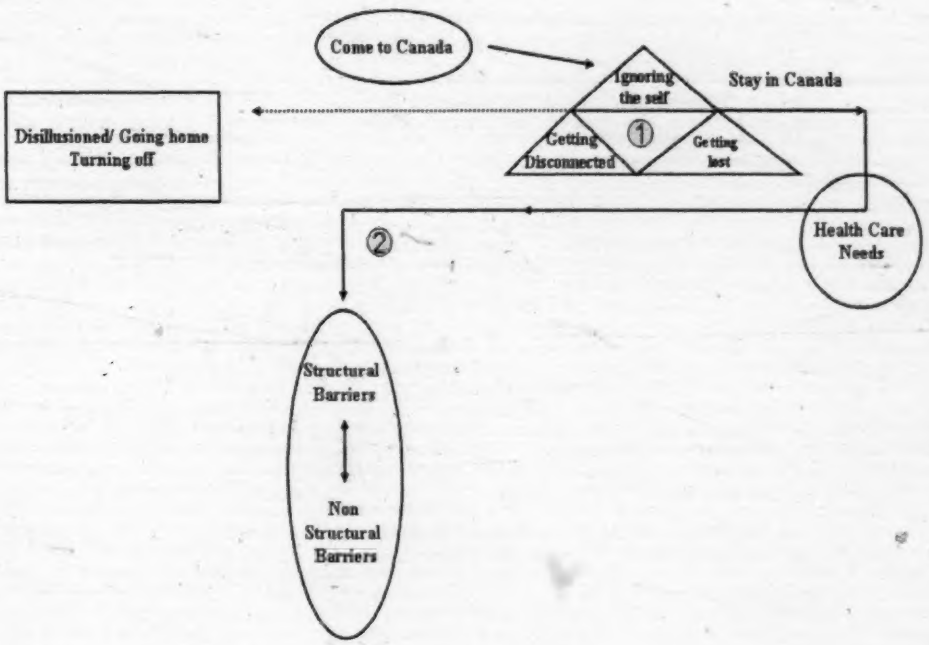
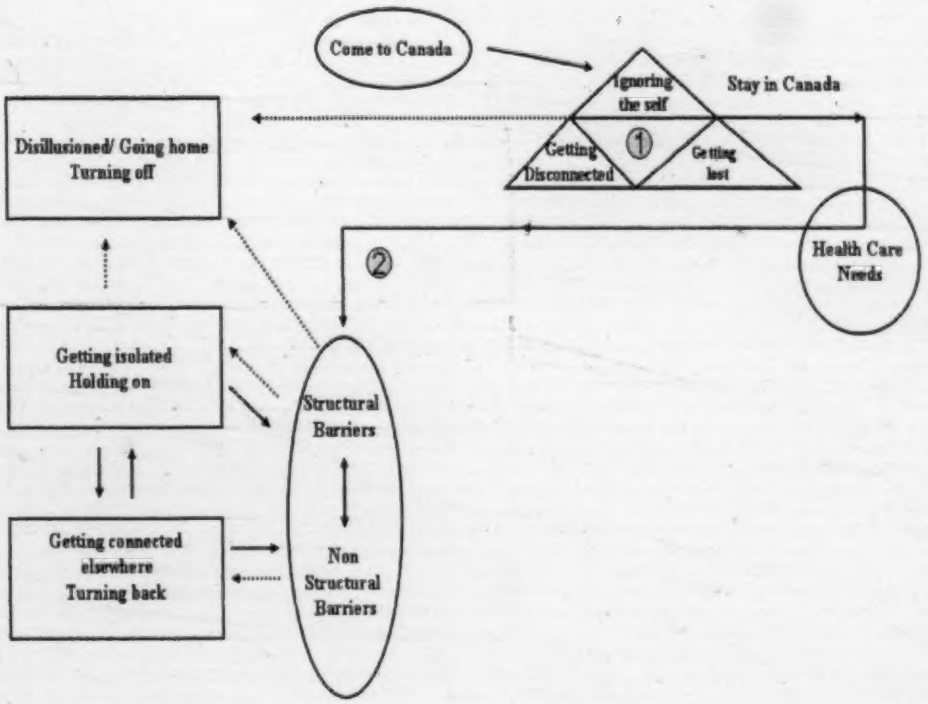


Figure 7. Going home (Turning off), Getting isolated (Holding on), and Getting reconnected elsewhere (Turning back)



disconnected from their new country but tried to reconnect to their country of origin through families and friends. Although they lived in Canada physically, they tried to meet their health needs from their home country, Iran (turning back) and reconnect to health care in Iran (Figure 7, 134).

The accessibility to and appropriateness of health care services for immigrants and refugees is a national concern (Health and Welfare Canada, 1990). Following Canada's acceptance of immigrants and refugees from politically and culturally diverse countries, the federal *Multiculturalism Act* was passed in 1988. The main goal of this legislation was to preserve and enhance multiculturalism in Canada. The *Act* emphasizes to policy makers that they should ensure that all programs are responsive to the needs of all Canadians and that services should be accessible to all (Heritage Canada, 2006).

In this section, I discuss the findings of my study pertaining to accessibility. Although accessibility is one of the most important principles of the C*anada Health Act* (2002), it is not sufficiently operationalized for immigrant populations. The theoretical argument of this study is that despite the egalitarian principle of health care in Canada and despite the existence of the *Multiculturalism Act* (1988), the institutional and the structural features of the health care services have limited the access of immigrants to health care in Canada.

Nonstructural Barriers

Communication Barriers

In pluralistic societies with increasing immigrant populations, interactions between patients and health care providers from different backgrounds are becoming routine. Although in a point-based selection system, the principal applicants should have some knowledge of English or French, this is not necessary for accompanying family members (Lee, 1994). This study revealed that the inability to communicate prevented participants from accessing health care services. In some cases, even if they gained access to health care services, from their perspective the services were not appropriate, acceptable, responsive, and effective with respect to their health needs. Accessing health care services and seeking help for individuals with limited language proficiency is very challenging, as they may be treated rudely, ignored, or denied services. Marshall, Konening, Grihorst, & Ewijik (1998) pointed out,

> Language barriers represent only one dimension of effective communication with immigrant or refugee patients. Cultural norms governing the structure and content of discourse in medical encounters are also vitally important. Beliefs and expectations concerning "appropriate" discourse in medical interactions—what is discussed, the timing of the conversation, who is present at the conversation, and who participates in the discussion—influence deliberation over ethical issues such as disclosure of medical information and confidentiality. (p. 211)

Language barriers seem to be a common issue for immigrants in areas such as health care access, assessment and management of illnesses, education, and socialization

(Juarbe, 1995). Language proficiency is one of the first challenges that immigrants face in their host countries and it plays the most essential role in access to all services, including health care. Roter and Hall (1997) emphasized on the importance of communication. They believed "Communication is both the most basic and the most powerful vehicle of health care" (p. 206). Limited English proficiency (LEP) prevents immigrants from interacting effectively and taking an active role in their own and their families' health. Many participants mentioned language barriers as their most serious block to accessing health care services.

Language barriers can hinder accurate meanings, emotions, and feedback. As a result, providers and patients cannot communicate very well, and the possibility of misunderstanding is very high. Lack of effective understanding and communication generates challenges to getting critical needs met. Immigrants usually obtain services from providers who have different cultural backgrounds and languages. Many studies in Canada have shown that immigrants and refugees experience linguistic and cultural barriers as one of the most evident barriers to health care services (Ballem, 1998; Blackford et al., 1997; Cave et al., 1995; D'Avanzo, 1992; Documet & Sharma, 2004; Searight, 2003). Many health care providers have mentioned language barriers as a major issue in providing quality health services (Bender et al., 2004; Documet & Sharma, 2004; Searight, 2003; Young, Spitzer, & Pang, 1999).

Individuals with LEP face both contextual and structural barriers to health care services that affect their access to care on many levels (Chang & Fortier, 1998; Timmins, 2002). A contextual barrier is defined as a barrier between health care providers and patients that limits communication with and understanding of each other. Language

affects how often immigrants visit doctors or consult with health care providers. Communication barriers also thwart immigrants from seeking and receiving proper treatment and care. Some participants mentioned that they did not like to visit doctors because they could not communicate with them.

Some providers believe that people with language and communication barriers are not competent and that working with them is frustrating. On the other hand, patients feel that doctors ignore them and that they have not been taken seriously. This experience hurts their feelings, and they get frustrated; as a result, they might not come back for treatment or for follow-up until their problems become severe. Care has two important components, medical and psychological. In the presence of language and communication barriers, doctors are more likely to focus on symptoms, assessment, and observation to choose appropriate treatments and diagnostic tests than on the psychological aspects of care. This missing part plays an important role, directly in patient satisfaction and indirectly in provider satisfaction.

People with LEP face many barriers at almost every level in health care services, and, as a result, they are excluded from programs. Fear, feelings of hopelessness, helplessness, limited language proficiency, financial limitations, and a lack of understanding of the Canadian health care system were common experiences among most of the participants in this study. The language barrier barred them from understanding how the Canadian health care system worked. All participants who had language barriers stated that they had difficulty using available services. They even did not know what services were available.

Research suggests that immigrants who do not have language skills have less access to health care services and also find it hard to describe their problems. Participants in my study described health care encounters as stressful, frustrating, and overwhelming experiences that discouraged them from using services later. Congruent with my findings, other studies reported that people with LEP and cultural differences may receive inadequate or inaccurate information about their health problems or inaccurate treatment, medications, prevention, and follow-up (Baker, Parker, Williams, Coates, & Pitkin, 1996; Bender et al., 2004; Flores et al., 2003; Ivanov, & Buck, 2002; Shapiro & Saltzer, 1981; Woloshin, Bickell, Schwartz, Gany & Welch, 1995; Woloshin, Schwartz, Katz & Welch, 1995). Language barriers can lead to miscommunication, misunderstanding and misdiagnosis (Bender et al., 2004; Ivanov, & Buck, 2002; Rai, 2002).

LEP patients might not understand their diagnosis, receive less information about their treatment, and not understand/ misunderstand medication instructions and medication regimens, as the instructions on medicine bottles are written in English (Bender et al., 2004; Ivanov, & Buck, 2002). Therefore, the possibility of making mistakes (Shapiro & Saltzer, 1981) that might intensify their medical condition increases. A study conducted by New California Media involving 600 ethnic media organizations showed that of 1,200 participants from 11 ethnic backgrounds, about 50% had limited English abilities and had difficulty understanding the medical situations and instructions they encountered (Parikh, 2003). In concurrence with the literature, one participant in my study experienced an overdose of medication because he misunderstood the pharmacist. He said the pharmacist was talking very fast and he could not catch up with him.

Manson (1988) found that individuals with language barriers often do not attend follow-up sessions and, consequently, are more likely to use the emergency room than are patients who do not have language barriers. A study showed that Latino immigrants are more likely than Whites to use emergency services (Chow, Jaffee, & Snowden, 2003). Participants in my study described reliance on emergency services, partly because they found that emergency services were quicker and more convenient than medicentre and doctors' office visits. In addition, they can sometimes obtain their medications from them for free. Congruent with the literature, in my study some participants mentioned that although waiting times were long and language barriers still existed, health care providers in Emergency departments asked fewer questions, had less paperwork, and were not limited to specific appointment times. They could get a ride or ask their spouse, relatives or friends for help. Also they did not need to take time off from their low paid job.

In summary, most problems arise with respect to communication between individuals and health care providers (Anderson, 1991; Dyck, 1992; Karmi, 1991). Anderson and Rodney (1999) emphasized that those immigrants who cannot speak or do not understand the official language are excluded from accessing the health care services that meet their health needs. If the health care system continues to neglect or inadequately address communication issues, the consequences for significant numbers of immigrant patients may be inappropriate treatment or costly and unnecessary diagnostic tests. Furthermore, language is an integral part of culture, and culture is transmitted through language. A different cultural background shapes the worldview of medicine, the

technical language that is used, and the way in which illness and symptoms are framed (Kleinman, 1988; Ventres & Gordon, 1990).

Cultural Differences

Another barrier to accessing health care services is cultural differences. Health care providers offer care to people with experiences and interpretations of health care services that might differ from their own (Anderson & Lynam, 1998). Immigrants may believe that if they ask questions and ask for help, they will lose face and honor in front of others. Generally speaking, Iranians, for cultural reasons, are shy about asking a lot of questions and asking for help. They prefer to face consequences or to be asked specific questions (Behjati-Sabet, 1990; Behjati-Sabet & Chambers, 2005; Hafizi, 1998). Some participants in this study pointed out that they did not ask for help and tried to put on a mask to hide their problems in front of others and their friends. They wanted to show them that they were doing "ok" as they did in Iran.

Anderson (1995) reported that participants in her study mentioned that their doctors did not understand their problems and considered health care providers insensitive, irresponsible, and uncooperative. This raises the issue of misunderstanding and conflict, and it creates a barrier between health care providers and clients that affects their relationship. When health care providers are ethnocentric and are not open to other cultures, they label clients as "not compliant" (Anderson, 1995), because the clients do not do what they are supposed to do. Therefore, misunderstandings will arise, creating a barrier to effective communication. The findings of this study resonated with the literature and revealed that Iranian immigrants had the same experience as other

immigrants. They mentioned that providers' behavior showed that providers, specially the young ones, did not understand them or did not like to deal with them. The structure of Canadian society suits the White, English-speaking majority population; this is called a "vertical mosaic" (Nakhaie, 1999), portraying the hierarchy of class, ethnicity, language, and religion (Lautard & Guppy, 1999).

Bayne-Smith (1996) believes that culture provides a lens through which "people interpret, assign meaning to, and develop a sense of what the world is about" (p. 29). Charon (1992) pointed out that language is central to one's culture and social interactions, and provides a framework for communicating the intent of interactions and for interpreting interactions. Other people's words, tone of voice, and facial expressions and mannerisms are interpreted and acted on based on people's cultural lenses (Lee, Pulvino, & Perrone, 1993). The perception and interpretation of some somatic feelings are defined by cultural idioms and might not be understood by providers from different cultures (Kleinman, 1988); furthermore, providers might have inaccurate assumptions about their patients' background and ethnicity. For example, because the majority of Iranians are Muslim, many people assumed that Iranians are Arabs or speak Arabic. As noted earlier, a participant said that she was referred to many different case managers and social workers who could not speak Persian (Farsi); they spoke Urdu, and Arabic. Another participant went through the same experience, and he felt humiliated. He assumed that the physician and the nurse ignored him. He interpreted physician and nurse's behaviors as strange based on his culture. His response showed that he did not know how the system works in Canada. He did not know that one of nurses' responsibilities is patient teaching and physicians refer their clients to nurses for more

information. Therefore, he got frustrated and felt humiliated when the explanation was not offered by the physician. Based on such judgments, immigrants make decisions to not ask for clarification or additional information.

Ignoring culture can put individuals' health at risk. One participant believed that health care providers should be more open to other cultures. Although science and medicine in Iran are the same as in Western countries (Behjati-Sabet & Chambers, 2005), some cultural values directly or indirectly affect the use of health care services. Fear of losing social face (*tars az bi arzesh shodan*) or of being rejected (*tard shodan*) by society is one of those values. Social acceptance is one of the most important values for Iranians, and it is accompanied by the fear of social rejection (Behjati-Sabet, 1990; Behjati-Sabet & Chambers, 2005; Sullivan, 2001). Being ignored or rejected is powerful enough to silence them and prevent them from asking for more information, or even asking their basic questions and raising concerns. Iranians have a keen sense of personal dignity and are very sensitive to criticism or insults. Ignorance is considered a big insult to them, and may make them feel threatened and uncomfortable (Dossa, 2004a & 2004b; Shahideh, 2004; & Sullivan, 2001). For Iranians, maintaining relationships is important; therefore, they make all efforts to avoid direct confrontation, disagreement, criticism, and questioning. Although Iranians are connected to and know how to help each other within the family circle, it is often difficult for them to connect and trust effectively outside the home (Behjati-Sabet, 1999; Behjati-Sabet & Chambers, 2005).

Providers who do not consider sociocultural factors may stereotype their patients falsely. This can affect the providers' behavior and clinical decision-making (Betancourt, Green, & Carrillo, 2002; Documet & Sharma, 2004). The effectiveness of the medical

encounter can be influenced by language and cultural styles of communication (Documet & Sharma, 2004; Erzinger, 1991). Two participants brought up the same problems that occurred while they were accessing health care services. They mentioned how it was hard for them to communicate with physicians. They thought that there was just one-way communication, from physician to patient, rather than reciprocity in the interaction.

Some participants mentioned that although they did not agree with their doctor, out of politeness and respect, a feeling of powerlessness, and the language barrier, they accepted their doctor's diagnosis and treatment regimen, did not speak up, and did not talk about their preferences with respect to procedures or care. To them, it was considered impolite to disagree. In addition, patients who experience a language barrier and cultural differences between themselves and their providers might sign a consent form for a diagnostic procedure or surgery without knowing either what they have signed or why they signed it, or without asking questions about the procedure or treatment. Most of the time, LEP patients sign forms without understanding them, because they trust the system and think they will not get abused or hurt. They think that by signing the forms, they are showing their appreciation, trust, and politeness. One participant shared his experience. He stated that he signed the consent form even though he did not know to what he was consenting. He added that he did not understand the explanation but thought it would be impolite to not sign the form. This raises the issue of ethics, particularly in critical conditions. As Putsch (1985) pointed out, a language barrier makes patients dependent on the person who holds the means to the whole clinical encounter.

The concept of "cultural safety" was developed by Maori people living in the New Zealand for addressing historically and politically mediated power relationships

(Ramsden, 1993, 2000), power inequalities, and individual and institutional discrimination (Papps & Ramsden, 1996). The main focus of the concept of "cultural safety" is changing attitudes through awareness of the political and historical forces that shape health care interactions with aboriginals. The concept of cultural safety can be extended to the study of immigrants. For instance, following the revolution in Iran, many political activists were arrested and jailed. It is important for Canadian health care providers to understand that not all former prisoners are drug dealers or criminals. Health care providers should be open to and accept immigrants as they are and not make assumptions about them.

As noted earlier, one participant, an educated political prisoner in Iran, knew almost nothing about her children's lives. She shared her painful experience when she went to a clinic when her children had the flu. She said that when the nurse at the clinic asked about her children's immunization histories, since she was a political prisoner in Iran, she knew nothing about them. She said that the nurse could not understand it and she thought that the participant was a careless mother. She stated that the nurse's comment was so hurtful that she left the clinic without saying one word.

Time orientation is an element of culture. For cultural reasons, Iranians are often not on time, which is not accepted by Western society. Iranians get upset when they are told that they are not responsible and do not show up on time for their appointments. One participant had the same issue. Once, she was late for her appointment and the nurse said that she missed her appointment. She considered the nurse a rude person because the nurse made a [big deal] of it. Participants who had the same experience mentioned that

they did not like to ask for help and preferred to ignore their problems if they could. These individuals lost trust in Canadian health care services.

Financial Limitations

Poverty or limited financial support is another issue that immigrants and ethnic minorities face (Documet & Sharma, 2004). A study by Health Canada (1999a) estimated that it takes about 10 to 14 years of residence before immigrants' earnings are equal to or surpass the earnings of the Canadian born, and that immigrants who come from Third World countries and visible minorities have lower incomes than individuals from developed countries. According to Lee (2000), the overall poverty rate of immigrants is 30%, which is higher than that of the Canadian-born population, at 21.6%. Poverty is still an issue in Canada, and poor families in Edmonton have less success in accessing health care services (Sin, Svenson, Cowie, & Paul Man, 2003; Williamson & Fast, 1998).

Many participants pointed out that to go to clinics they had to take buses, involving travel that took a lot of time and for which they had to take unpaid time off work. Participants often had to travel with their children, as they did not have anyone to look after their children and could not afford babysitters. Thus, they ignored their problems.

Another barrier is health insurance (Documet & Sharma, 2004). Some participants stated that because of low-paying jobs, they could not afford monthly health care insurance. Although these participants were working, they did not have benefits. Some were not aware of the waiving option, which provides a discount for people with low income. They needed information from knowledgeable individuals.

Structural Barriers

Not having flexible hours to visit doctors in hospitals, clinics, and doctors' offices is another barrier. Lower income immigrants consider fixed appointments to be important barriers to accessing health care services (Fitch, Greenberg, Cava, Spaner, & Taylor, 1998). Fitch and colleagues also found that immigrants are not satisfied with health care services, not only because the waiting time to visit doctors is long but also because doctors spend only a short time with them, although they should allocate more time for immigrants because of the language barrier.

In addition to the above mentioned problems, having different value systems might be considered another barrier to health care services. Lee and Herrera (1995) have challenged reports of multicultural access to public health services by mentioning that although governments and academics agree on diversity, within medical policy and procedures it is missing, and government agencies at different levels are not working together to help newcomers. Therefore, not much has been done to ease this problem. Although the Canadian medical system cannot relax its standards out of concern for Canadians' lives, there are still some roadblocks, such as cost and the length of the upgrading programs, to accepting well-trained internationally-educated health care professionals.

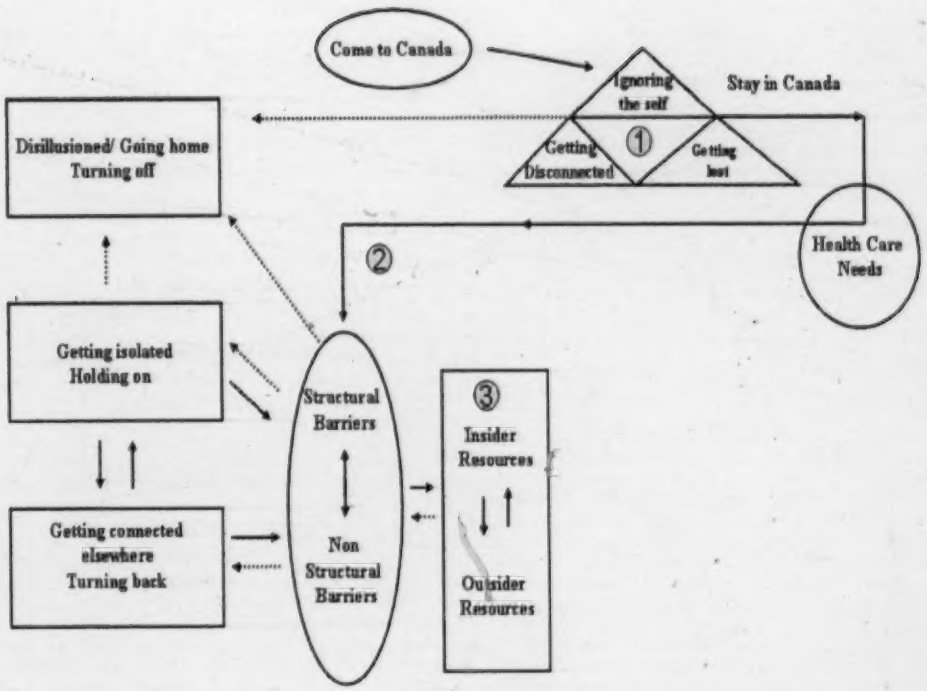
In summary as it is shown in this stage (entry point) (Figures 6 & 7, pp. 129,130), some participants could not tolerate this situation and returned to Iran (turning off). Those who could not return to Iran because of their political/religious backgrounds or because their children had to stay, chose different solutions. Some became isolated and ignored their problems until they became critical (holding on). Some tried to get help from other

sources, such as families, relatives, or friends in other countries or Iran (turning back). This group of people physically lived in Canada and asked for help for minor problems, but they got most medical needs met from Iran. Since they did not go to any clinics or family physicians in Canada, they did not have a record of their health status. At this stage, those who decided to stay in Canada and wanted to get help moved to the next stage.

Stages 3 and 4: Navigating, Seeking and Employing Strategies

In stage three, called Navigating and Seeking, participants experienced transition through recognizing the need to know about new health care services (Phase one), discovering the differences in the health care services (Phase two), and searching for resources (Phase three) (Figure 8, p. 149). Regarding seeking information, participants took different methods based on their education, ability in English, and previous experiences. Those who had communication barriers tried to get most of their information from families, relatives, friends, or other Iranians. Some, although they had communication barriers, did not want to communicate with other Iranians and tried to get help from Canadians. They also tried to find other resources, such as books, Iranian Satellite broadcasting from the United States, the Internet, and asking librarians for more information. Others stated that they obtained their information through Canadians, libraries, free brochures, magazines, and the Internet. Some participants mentioned that they learned that they had to get information by asking and sharing their problems with others. Those who did not have communication barriers, following their previous experiences of living in other countries before coming to Canada, got their information from Canadians or Iranians who had been living in Canada for years as they were

Figure 8. Stage Three: Navigating/ Seeking (Transition Point)

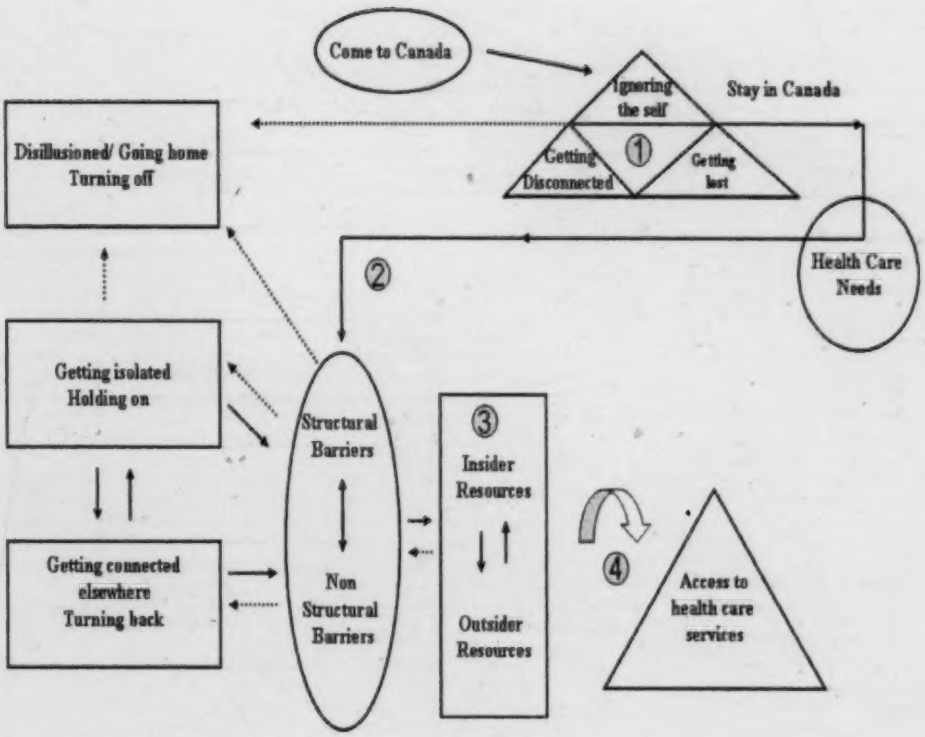


considered trustworthy sources.

After this phase, participants move on to next phase, "recognizing the differences in the health care system." Although they recognized that Canadian health care services were different from those in Iran, they resisted accepting it; they did not like it and tried to get away from or criticized it. In this phase, they usually compared health care services in Canada with those in Iran. Although participants were not homogenous and had different backgrounds and experiences of the services in Iran, most stated that they had different expectations. Some appreciated the Canadian public health care services, but those who had had high-standard care from private services in Iran were unhappy. Those who had previous experience in different countries accepted the different health care system. They did not feel that they did not have voices or power concerning their treatments. Overall, they liked the Canadian public health care services and appreciated them. They had a different opinion regarding power, voice, and choice over their treatment from those with no previous experience.

In phase three, participants shared their experiences of searching for resources. The Western structure of the health care system might lack the resources to provide linguistically and culturally diverse interpretation and translation services, especially for smaller minority groups. This study showed that to access health care services, participants used both outsider and/or insider resources. Generally speaking, Iranians are very family-centered and prefer to get help from their own families rather than from others (Behjati-Sabet, 1990; Behjati-Sabet & Chambers, 2005). At this time, they moved to stage four (Figure 9, p. 151); employing strategies, and using insider and outsider resources in order to access and use health care services. They considered all available

Figure 9. Stage Four: Employing strategies (Turning point)



options (phase one) and evaluated their outcomes (phase two).

One strategy was to get help from families or close relatives. Of those who did not have help from their families, some asked friends and some preferred not to ask their relatives or friends to help them. Individuals who did not like to talk about their problems with friends, relatives or other Iranians preferred to get help from public services and Canadians. Because this group of people had communication barriers and did not know how the system works in Canada, they faced many challenges.

Participants who had language barriers used insider resources such families, relatives, friends, or other Iranians who were easy to reach and with whom they did not have communication or cultural barriers. Some participants received good support and help; others were misled. Those who were misled tried to get some help from outsider resources. Because both groups had communication barriers and could not speak English fluently, they relied on interpreters. The first group used families, relatives, and friends as interpreters; the others asked for professional or other interpreters. Many participants pointed out that it was a very frustrating experience, involving a lot of trial and error and going back and forth between insider and outsider resources to break the obstacles of access. Although interpreters were one of the available resources, most of participants from both groups had issues around the accessibility and quality of interpreter services.

Many studies have been done related to interpreter services. Although such services facilitate equal access to health care services for those who have a language barrier, they are not always available for all languages or all health care encounters (Anderson & Reimer Kirkham, 1998). Often bilingual individuals such as employees, other patients, family members, or visitors who are not trained to provide medical

interpretation are asked to be interpreters. Because of a lack of funding, this is becoming a formal practice and may be considered routine. Although some research has shown that families, relatives, and friends play an important role in how and when newcomers use health care services (Doherty & Campbell, 1988; Litman & Venters, 1979; Ross, Mirowsky, & Goldsteen, 1990; Schor, Starfield, Stidley, & Hankin, 1987), this informal system has disadvantages (Ivanov & Buck, 2002).

Because of the limited number of part-time and full-time interpreters, it takes time to provide interpreters for patients; therefore, there is delay in care from the time when the patients make appointments to when they see their physicians. Sometimes, although medical interpreters are available, patients do not ask for them, especially in places where it costs money and they cannot afford this extra cost to their treatment. A lack of interpreter services might discourage immigrants from using the health care system (Globerman, 1998). Because interpreter services are not provided in all health care facilities, it is the clients' responsibility to ask for an interpreter. Sometimes the waiting line is long, and interpreters have to leave; in this case, the patients are supposed to ask for another appointment and reschedule the interpreter. Often, they do not get the same interpreter, which is very overwhelming for patients, who must introduce themselves and talk about their problems many times. Delays in receiving care and going through rescheduling for physicians' and interpreters' appointments were familiar phenomena for most of the participants in this study.

Some individuals who are not successful in finding an interpreter try to get help from nonprofessional people, such as friends or family members who can speak English. Although immigrants who have a language barrier ask family members, children, or

friends to help them, they often do not feel comfortable with this option (Anderson, 1998; Meadows, Thurston, & Melton, 2001), as it jeopardizes privacy and confidentiality. Sometimes patients are afraid or ashamed of revealing signs or symptoms of their problem in front of a family member or friend, especially in front of the opposite sex (Baker, Hayes, & Pubela-Fortier, 1998). Lack of trust and fear of disclosure are elements that might affect client-provider power relations (Pinderhughes, 1989). Clients may try to keep some of their issues private and intentionally misrepresent their symptoms in order to save face in front of people in general and their community in particular. In this regard, one participant said that she had her friend as interpreter while visiting the physician. She skipped the answers to some questions or answered them wrongly because she did not want to talk about private matters in front of her friend.

In addition, some researchers found that in the presence of interpreters role conflict may occur, because interpreters expand their role to become advocates and cultural brokers (Kaufert & Koolage, 1984; Kaufer, O'Neil, & Koolage, 1985). Health care providers must keep in mind that family interpreters are also family members. They participate in decision making about their family member's condition in the same way as other family members do. However, because they have been put in a situation in which they have more power and are more trusted, they unconsciously interact more than other family members do. In this situation, the interpreters' role may become more dominant than that of the patient.

In addition, when family members become interpreters, their position changes from that of a family member to that of a family interpreter. This new position gives them more honor and power, although they might not be aware of it. It can become

problematic when interpreters are children or young family members, especially in families in which age is an important factor associated with wisdom and power. Some cultures are family hierarchy oriented, with authority always running from older to younger and sometimes from men to women. The head of the family is responsible for making a decision or advising others. In this situation, if the patient is the head of family, he or she will lose that authority and become dependent on a younger family member. This power change is a source of stress for patients. Moreover, sometimes children take advantage of the situation, using their power over their parents and not respecting them as usual. Using children or young family members as interpreters puts the family structure in jeopardy, and interference in the family structure interrupts the family's social order, creating another crisis or stress for patients (Haffiner, 1992).

Although using trusted family members and friends as interpreters helps patients to obtain services, these individuals might have limited English proficiency. They might not understand or interpret the medical terms correctly, as the terms are linguistically and culturally bound. Mere translation or interpretation not only might not help but might make things worse, if it is incorrect. One participant mentioned that having an interpreter was not helpful because she did not know medical terms in English and in Persian. Untrained interpreters are likely to experience such problems.

In addition, interpreters might make decisions by themselves or force patients to accept or reject treatments, and because of the language barrier, the patients cannot reject the interpreters' ideas or negotiate. As Putsch (1985) pointed out, family interpreters not only can manipulate the information exchange, they also can manipulate the situation.

Sometimes, interpreters do not want to hurt their family members by delivering bad news and do not translate the diagnosis to the patient. They want to protect their loved ones.

Besides, in some cultures, it is not appropriate to deliver bad news to a patient; therefore, family members, rather than patients, contribute to making decisions about treatments. They want to keep the patient's quality of life good and not destroy hope. This raises another issue. Family interpreters may take away patients' rights concerning their lives and treatments. Sometimes, family members do not agree with a treatment or with having more diagnostic tests, and they sign or refuse to sign consent forms on behalf of patients (Baker et al., 1998). In some situations, it might be culturally inappropriate and considered immoral to disclose patients' diagnosis to their families and friends, and so using family members or friends as interpreters is unethical.

Although having interpreters helps and eases communication between health care professionals and patients, it keeps patients from being active in the dialogue. Interpreters behave as information gatekeepers, make decisions, and select what kind of information should be exchanged. In addition, interpreters often bring their own beliefs and their personal agendas into the interaction (Kaufert & Koolage, 1984; Kaufert & O'Neil, 1990; Kaufert, O'Neil, & Koolage, 1985; Kaufert & Putsch, 1997). One participant expressed dissatisfaction with interpretation services because the physician and the interpreter talked to each other rather than incorporate her into their dialogue.

Interpreted communication is very complex. Many issues arise, such as bad paraphrasing, impatience, the lack of linguistic equivalences, interpreter beliefs, ethnocentrism, and role conflicts (Jackson, 1998). Language in general, and language of disease in particular, is culturally constructed. Incorrect interpretations of words may lead

to misdiagnoses. Although having interpreters helps immigrants who cannot speak the host country's official language, some studies have shown that because of misinterpretation, the information exchanged between clients and health providers was not effective or helpful (Sue & Sue, 1987).

Sechrest, Fay, and Hafeez-Zaidi (1972) stated that there are various types of translation problems. These equivalence issues hold true both for translation (written) and interpretation (oral). They distinguished five types of equivalence in translation: vocabulary equivalence, idiomatic equivalence, grammatical-syntactical equivalence, experiential equivalence, and conceptual equivalence. Vocabulary equivalence refers to having equal words in translation. In many languages, there are no equivalent words in translation. Idiomatic equivalence refers to idioms, and because idioms always are language specific, they cannot be translated to other languages. Idioms translated to other languages often lose their meaning. Grammatical-syntactical equivalences are defined as parts of speech: present, past, absent, future, and conditional. Experiential equivalence refers to familiar and real things and experiences as the point of reference, which is common to both cultures. Conceptual equivalence refers to multiple linguistic associations of particular words, such as their linkage to other words, and their conceptual associations.

When patients and physicians belong to different cultures, some words, experiences, and contexts will not be translatable. Interpreters should be fluent in both languages and should be trained as medical interpreters. They should also come from the same culture and be aware of cultural and contextual factors. Different levels of understanding and different cultural backgrounds among participants (health care

professionals-interpreters-patients) in the interaction increase the complexities of the situation (Marshall, Konening, Grifhorst, & Ewijk, 1998).

Stevenson, Thomas, and Romagoza (2002) provided an example of this misunderstanding of the word "butterflies," when a Hispanic woman was admitted to an emergency room in Southern Florida. An incorrect interpretation of the symptom "butterflies in her stomach" led to the patient's referral to an expensive intensive care unit, although she had only mild food poisoning. Emami et al (2001) insisted on the power of communication and correct translation. She pointed out that one client had a hemorrhagic hemorrhoid but because it was interpreted as having some bleeding from his back rather than his anus, the doctor did not take it very seriously. As a result, the man suffered from severe bleeding and was later sent to Emergency. In my study, one participant stated that his interpreter translated the symptoms word by word to English and the physician did not understand what he meant and what his problem was.

Good and Good (1977) pointed out that central to the interpretation issue for patients and physicians is that they have different cultures. For example, they found that among rural Iranian women in a village, the chief complaint was "heart distress." Some physicians were frustrated in trying to find the origin of the problem, because most of the time, although the women complained of heart distress, this did not mean they had an organic heart problem. They considered the heart a center for emotional and psychological stress, such as being anxious, nervous, worried, poor, concerned, or old, taking contraceptives, or having too little blood. Good and Good concluded that "heart stress" complaints were part of a "semantic network," which they defined as more than a group of syndromes. It is

> a syndrome of typical experiences, a set of words, experiences, and feelings which typically run together for the members of a society. Such a syndrome is not merely a reflection of symptoms linked with each other in natural reality, but a set of experiences associated through networks of meaning and social interactions in a society. (p. 27)

Sometimes, patients believe that they can explain for their doctors and do not need an interpreter, or else their interpreter is a family member (Emami, 2001). Sometimes health care providers do not understand what immigrants mean because the client cannot express what they want to say. As Jackson (1998) stated,

> Most clinicians are keenly aware that the technical paradigms of science and lay paradigms of illness are incongruent, and they struggle to adapt the technical thinking of biomedicine to the individual and social contexts of their patients. When gender, class, and culture must be negotiated in addition to medical thinking, the struggle is complex and delicate. Physicians rely on input from interpreters to negotiate these differences. If the physician is uninformed about the common semantics of illness in the patient population, it is impossible to address the issue. (p. 66)

Jezewski (1990) pointed out that having an interpreter is not enough for successful communication between clients and health care providers. Cultural brokers were suggested as one of the answers for overcoming communication barriers. Jezewski (1990) has defined cultural brokering as the "act of bridging, linking, and mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change" (p. 497), and of bridging the gaps in understanding

between health professionals, patients, their community, and the broader social system (Jezewski, 1989, 1990, 1993a,1993b,1993c). According to Jezewski (1989, 1993c), the model of cultural brokering has three stages—initiation, intervention, and resolution—through the processes of mediating, negotiating, sensitizing, innovating, and advocating. This process for providing professional and successful services to immigrants and individuals who are linguistically-culturally different from the mainstream population was perceived as a key to overcoming linguistic and cultural differences in cross-cultural health care encounters. Cultural brokers are interpreters in a very broad sense. They interpret across both language barriers and cultural differences, thus contributing to greater understanding of the health care situation for both the client and the health care provider.

Other Resources

Participants mentioned that they used other insider and outsider resources in making health care decisions. The public library and librarians were considered to be one of the most valuable resources. I found no literature to support this finding that librarians were a particularly useful resource. Talking to Canadians, reading free pamphlets and booklets, and searching the Internet were other options that helped them to get information and help. Although participants were reluctant to use free pamphelets when they first entered to Canada, they later realized that the information was reliable and helpful. However, they were not able to use them due to language barrier.

Another option was trying to find Iranian physicians who are considered both insider and outsider resources (Behjati-Sabet & Chambers, 2005). They were seen as

insider resources because they were from the same culture and could speak the same language, were knowledgeable about medicine in Iran, and were familiar with the history of the country, but as outsider resources because they were practicing in Canada and could explain how things work in Canada. Some participants mentioned that they had to go back and forth between insider and outsider resources. They did not find Iranians knowledgeable enough to help them.

Some were happy with getting help from Iranians who have lived in Canada for a long time and considered them insider resources. Although some participants mentioned that they had communication barriers or did not know how Canadian health care services work, they preferred to use only outsider resources. At this stage some participants still mentioned that they were not satisfied with health care services and tried to use resources outside of Canada, but none of them returned to Iran to stay. Participants who could not move to the next stage and were dissatisfied with insider and outsider resources moved back to stage two and dealt with barriers. A few even turned away, completely disconnected themselves from Canadian health care services, and reconnected to the health care services in Iran.

One participant stated that he called and got help from Iranian practicing doctors in the USA as one of his options. Another participant had a different strategy to solve her problem. At first, she chose self-treatment and self-medication. Those who could move on by navigating resources and recognizing them moved to stage four. This stage is called a turning point because through weighing options, and dealing with barriers (turning the/a key) (Phase one), and evaluating outcomes (Phase two), participants could face and solve their problems. One participant who had accepted Canadian health care

services and does not experience any communication barriers in accessing and using services stated that when she was new in this country, could not speak English, and did not know how the system worked, she was "freaked out". Her first strategy was to call home (Iran) and ask her mother's opinions. Another strategy was to choose Iranians as a resource to get more knowledge while visiting her doctor. In this way the situation could be understood better, allowing more sharing and active participation in treatment.

This shows that people who had communication barriers tried to apply strategies that they were familiar and comfortable with and could trust. However, those who wanted to be independent put a lot of effort, energy, and time into educating themselves, learning the language, and finding out how the system works. One participant made the decision to ask her Canadian landlady to help her rather than asking Iranians. She liked to deal with health care services in the same ways that Canadians do. She said that to do this, she would have to be fluent in English and try to talk about her problems with others. Her strategy was to become integrated into the Canadian lifestyle.

My findings concerning the different strategies used by Iranian immigrants in navigating Canadian health care services are supported by Leduc and Proulx (2004). They studied the pattern of health services utilization by recent immigrants from Algeria, the Philippines, and Sri Lanka who lived in Montréal. They found a triphasic pattern of utilization, such as using one or more health services, selecting specific services from those available, and consolidating choices. They found that families relied on a variety of resources and information in each phase of adjustment to life in Canada. Although Leduc and Proulx's study was more focused than my study on Iranian immigrants' access to health care services, there are some similarities such as language barriers, relying on

families and friends, being more comfortable with health care providers from their home countries, using emergency facilities, using clinics instead of emergency departments over time, and becoming familiar with services. Although participants were from different countries, the patterns of utilization were similar.

Participants' evaluations of the health care services were strongly related to language mastery, how familiar they were with Canadian society, and how well they were integrated into it. For the reasons mentioned, because of communication barriers and not being integrated into Canadian society, participants changed physicians many times or used emergency departments even though their problems were not emergencies. They also used insider and outsider resources, self treatment, and self medication, but still were not happy and satisfied with Canadian health care services. In this study, the dynamic pattern of use, misuse, and failure to use was obvious.

Participants mentioned that although many services are available to immigrants, they do not run appropriately and effectively. Health care services are not responsive to immigrants' needs. They appear to be based on an exclusive viewpoint that does not welcome those whose skin is not white and/or who speak a different language. Participants mentioned that furthermore, health care services are not designed to answer immigrants' needs, although they are considered Canadians who have equal rights to access health care services. Although participants went through the same process as Canadians, they responded differently. This process was tiring for some immigrants who became isolated, while others become mentors and role models. They helped others to become integrated into the Canadian community and become independent. Analysis of the interviews and scrutiny of the data revealed that these individuals were more

acculturated than those who experienced more difficulty accessing health care services. Therefore, in the next chapter, I will talk about the last stage (stage five) and the role of acculturation in becoming self-sufficient and integrated. Before doing so, I will address two key issues that seem to underlie my data; namely, issues of power and issues related to discrimination.

Power

An important variable in accessing health care services is the issue of asymmetric client-provider power. In health care settings, providers and organizations usually have unintentional power over clients. Power relations between the provider and the client, and communication problems even for patients who speak English, can be problematic. These problems can be magnified when patients are unable to speak and understand English or the culture of the dominant society. Betancourt, Green and Carrillo (2002) mentioned some problems reported by English speakers, such as having doctors who did not listen to what they said, not understanding what doctors told them, and having questions during the visit but not having the chance to ask them. In the instance of communication barriers, providers tend to focus on symptoms of disease and exclude patients' feelings, emotions, and questions about their illnesses (Rivadeneyra, Elderkin-Thompson, Silver, & Waitzkin, 2000). This situation creates different feelings on the part of providers and patients toward each other. In concurrence with the literature, one participant thought that health care providers did not like working with immigrants, because immigrants were considered noncompliant and problematic patients.

One example of power over clients is the technical language used by providers and the asking of very specific, usually closed-ended questions to gain the information needed from clients for a quick diagnosis. In this situation, by answering closed-ended questions and saying "yes" or "no," clients do not have the opportunity to discuss their issues and concerns. Although providers most likely assume that this method is for the sake of their clients, it makes the clients dependent on their care providers (Pappas, 1990) and shows the issue of asymmetric client-provider power. When interpreters are present, both the care providers and the clients depend on the interpreters, who facilitate the session. Because the interpreters facilitate the communication and providers make the decisions, both the interpreters and the care providers have more power than the clients, who are fully dependent on the interpreters and care providers. As time is always crucial and very limited, most of the conversation often takes place between interpreters and the care providers, and clients are eliminated from active participation and are ignored. In this situation, clients do not have an opportunity to bond with their care providers and do not feel comfortable with them.

Globerman (1999) pointed out, "If you look at people's unease about the health care system, it's not because they have found it is less than satisfying to use. It has to do with their fear that it won't be there if they need it" (p. 34). Immigrants' needs should be met, and a language barrier is not an excuse for leaving patients uninformed or lacking desired information about their health condition. Language was the primary conflicting issue experienced by Iranian immigrants. This was mentioned by most participants when they talked about challenges in accessing health care services, including knowing where to go, whom to talk to, what was done at a visit, what needed to be done, and what to

bring for the next visit. Participants mentioned feeling frustrated and powerless in their visits.

Discrimination/ Perceived Discrimination

Equity has been defined as the state of being equal or applying in the same way to all people or in all circumstances (Kipfer, 2006), and in the literature, it is referred to as being "just and fair" (Brich & Abelson, 1993; Calman, 1997; Daniels, 1982). Daniels pointed out that equity has two dimensions: equality and distributive justice. Equality means giving everyone the same opportunity without barriers to achieving human potentials, whereas distributive justice refers to taking extra positive steps to compensate for different social and natural disparities for minorities.

Equity of access to health care means that all people have equal opportunities of access to available recourses, to develop and maintain their health through a fair distribution of these resources (Ziglio, Hagard, McMahon, Harvey, & Levin, 2000). In the literature, equity of access to health care services has focused on the rates of the utilization of health care services, but the fact that individuals do not use the system does not mean that they are healthy. Therefore, equity of access to health care services means that all people have the opportunity to use the services for their health needs or to maintain their health status.

Strafield (2000) has defined equity as "absence of systematic inequality across population groups" (p. 7), whereas equity in health means "everyone should have an opportunity to attain their full potential for health, noting that variations and inequalities among populations may be unavoidable" (Calman, 2000, p. 2). According to Dua and

Robertson (1999), immigrants face "systemic discrimination," which they defined as discrimination that is "manifested in the policies, practices and procedures of institutions, which may directly or indirectly promote, sustain, or entrench differential advantage or privileges for racialized groups" (p. 14). Systemic discrimination forces immigrants to resist and refuse health care services which leads to the potential for lower health status.

Hooper, Comstock, Goodwin, and Goodwin (1982) reported that physicians conducted better interviews with and expressed more empathy toward Anglo patients compared to Latino patients. Jones (2000) classified racism into three levels: institutionalized, personally mediated, and internalized. Institutionalized racism is defined as differential access to the goods, services, and opportunities of society by race, which can vary from subtle to very blatant. Personally mediated racism is defined as prejudice, which means differential assumptions about the abilities, motives, and intentions of others, and discrimination, which means differential actions toward others according to their race. Personally mediated racism can play an important role in the allocation of funding and the implementation of programs that would improve linguistically and culturally appropriate access to health care services.

The third level of racism is labeled as internalized racism (Jones, 2000), which means that marginalized people accept the negative message about their abilities and fundamental worth. They do not ask questions or talk about their concerns and fears about their treatment because of feelings of being stupid or rude, or of losing the opportunity to get treatment or other services. They are always grateful for what they have been offered. Often, immigrants are not aware of discrimination because of the language barrier and their sense of being subservient. "All too frequently victims of

discrimination in the health care setting do not even know they have been discriminated against. They are simply grateful that somebody looked at them" (Perez, 2001, p. 219).

Some studies have shown that there are prejudices toward LEP patients. Perez (2001) mentioned that cultural stereotypes and bigotry toward LEP patients marginalize them from the mainstream population. He pointed out, "we cannot begin to eliminate racial and ethnic disparities by ignoring the role of discrimination" (p. 217). Prejudice and discrimination can influence the provision of health care services and also the patient's decision to seek care (Documet & Sharma, 2004). Stereotyping might be the outcome of the rushed doctors' need to multitask in a fast-paced hospital or clinic atmosphere. Whatever the reason, both perceived and actual experiences of discrimination can lead to patients' reluctance to seek care, lack of treatment acceptance, and lack of desire to return for follow-up (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). In a study of Latino immigrants, perceived discrimination was seen as being a great barrier to accessing health care services (Smith, 2001).

Systemic discrimination may make some health care services inappropriate and, as a result, inaccessible for immigrants, which it is not consistent with the accessibility and universality principles of the *Canada Health Act* (2002). For example, because many immigrants have underpaid jobs they are hesitant to ask for time off work to visit their doctors. They are worried about losing their job, or, at least, they lose pay for the time they are gone. This is true for other Canadians in marginal or low-paid jobs as well.

It is well documented that because of historical mistrust of health care and social service professionals, perceptions of prejudice or discrimination, and communication barriers, ethnic minorities are more likely to delay access to care (National Institute of

Health, 2002). Lack of trust in health professionals can explain why racial and ethic minorities are less likely to seek care or do not follow medical advice (Ivanov & Buck, 2002; Wolf, 2001). Fear of being deported affects immigrants' trust in general and of the health care services and health care providers in particular, which might even influence the pattern of care-seeking behavior. In this regard, a participant talked about his fears. He said that he was afraid of talking about his illness. What if they deport him to Iran? He preferred to live in fear and die in Canada rather than being sent back to Iran and get killed there.

Boulware, Cooper, Ratner, LaVeist, and Powe (2003) stated, "patterns of trust in components of our health care-system differ by race" (p. 385), which might reflect differences in care-seeking behavior and differences in expectations for care. Mistrust of health care providers might lead patients to not follow medical advice. In concurrence with the literature, participants in this study mentioned that they could not trust health care services and health care providers. Health care providers/professionals need to be aware of the influence of values on seeking care. Building trust is very important, and "once their trust has been gained, Middle Easterners show a strong faith in their practitioners and are very cooperative" (Lipson & Meleis, 1983, p. 861).

In this study, a sense of inferiority and perceived discrimination were related to having an accent, dark skin, and being Iranian, which were factors mentioned by Iranian participants as factors related to discrimination that made them not seek health care services or caused them to lose their trust in the Canadian health care system. Individuals' help-seeking behavior can be affected by perceptions of being judged and discriminated against.

Perceived discrimination may lead to mistrust of health care providers, resulting in delays to accessing health care services or getting treatments (Satcher, 1999). Research has shown that although the majority of health care providers do not intend to discriminate, even "well-meaning people who are not overtly biased or prejudiced typically demonstrate unconscious negative racial attitudes and stereotypes" (Lavizzo-Mourey, 2002, p. 15). Emami and colleagues (2000), in an ethnographic study of Iranian immigrant seniors in Sweden, reported that they did not truly trust health care providers in general and physicians in particular. One 60-year-old Iranian participant said that her physician "didn't understand the Persian pain" (Lipson, 1992, p. 19).

In conclusion, the findings of this study showed that some participants had problems accessing health care services because of barriers related to communication, cultural differences, limited finances, power, perceived discrimination, and the structure of health care services. Some Iranian immigrants underutilized or misused health care services because of communication barriers, a lack of knowledge about resources, and financial limitations. Some suffered from shame and frustration, because they could not express themselves clearly about their health problems to physicians, explain their concerns, or be active in making decisions. Immigrants with limited English proficiency and knowledge of health care services avoid using, navigating, and accessing services on arrival and shortly afterward. They neglect and ignore their health problems and avoid health care because of the overwhelming stress of resettlement. When they need to use health care, new challenges and frustrations in finding and accessing physicians, health professionals, clinics, or hospitals come into their lives.

Most participants described their status in health care as a consequence of being a lower class invisible minority about whose issues no one cares. Many felt dehumanized, devalued, and powerless when placed in a situation that contradicts what they perceive themselves as entitled to as Canadian residents. Because of the unsatisfactory results experienced when seeking health care, many resented their inability to use these services. Most expressed feelings of powerlessness, and defended the roles they felt forced to play to receive even the most inadequate services.

Although the *Canadian Multiculturalism Act* (1988) supports the languages and heritages of all ethnic groups, it has not been successful in diminishing barriers to access (Henry & Tator, 1999). Rather, the barriers described above contribute to increased health risks in immigrants. Young et al. (1999) described the manifestation of the above barriers. They found that economic issues, such as financial stress due to underemployment and lower income, poor living conditions, and overwork; social problems, particularly racism and discrimination in schools, as well as the lack of a social support network; and specific health care issues relating to unfamiliarity with the health care system, cultural misunderstanding between clients and health care providers, and inflexibility of the medical regimen with regard to treatment plans as main barriers in integration into Canadian mainstream.

Browning (2001) believed that there are many reasons why immigrants and ethnic minorities might not seek or receive care, which might be cultural, economic, or both. Williamson and Fast (1998) concluded that the accessibility and universality principles of the *Canada Health Act* have not been achieved. Lavizzo-Mourey (2002) pointed out that although factors such as lack of access, low income, and poor insurance coverage

"contribute to health-care disparities; there may be something more insidious at play. Difficult though it is to admit, racial prejudice persists in medical practice, perhaps unconsciously but in a very real way" (p.1).

This study revealed intertwined and very complex phenomena. It has shown that participants had many struggles accessing health care services. In the process of using insider and outsider resources to access health care services in the light of structural and nonstructural barriers, they were struggling with other issues, such as powerlessness and discrimination. Although these issues were not main issues, they influenced participants' access to, their trust in, and satisfaction with health care services.

CHAPTER VI

BECOMING SELF-SUFFICIENT AND INTEGRATED

Participants in this study are first-generation Iranian immigrants or refugees. The 1979 Islamic Revolution in Iran and its aftermath, which saw revolutionary upheaval, political and social changes, war, unemployment, and the like, was the main impetus to both voluntary and forced immigration to Europe and North America from Iran. The United Nations High Commissioner for Refugees (UNHCR) reported the astonishing fact that "1 in every 15 people on earth is now on the run in some kind of exile" (1995, sec. 4:3). At the end of 2001 there were more than 12 million refugees and asylum seekers worldwide (UNHCR, 2002a & 2002b).

Many Iranians who were abroad for educational or professional reasons made the decision to remain outside Iran after the revolution. Since then, many factors, such as social, political, professional, and educational reasons, have caused Iranians to leave their home country (Ansari, 1988). Pliskin (1987) has pointed out that Iranian immigrants had been economically well off in Iran. Most were factory owners, import-export merchants, antique dealers, physicians, engineers, pharmacists, and dentists. As a result, Iranian immigrants are different from many other immigrant groups to Canada and are better educated (Moghaddam, Tylor, & Lalonde, 1987). Wiking, Johansson and Sundquist (2006) pointed out that reasons for immigration from Iran to Sweden were related to political matters, religions issues, or war. Carrington and Detragiache (1999) reported that among Asian countries Iran has experienced a sizable and substantial brain drain (individuals with tertiary education). Sabagh and Bozorgmeher (1987) pointed out that

Iranians did not immigrate for economic mobility; rather, many of them experienced a loss of social and economic status as a result of immigration. The impact of this immigration is likely significant since a large proportion of the immigrants are educated at tertiary level (13 years or more of schooling).

Iranian refugees usually are well-educated members of social elites, politically active, and with great ambition to contribute to social changes in Iran rather than leaving Iran for good. Individuals who choose to seek opportunities in another country might adapt better in the host countries compared to those who leave their countries involuntarily and cannot return to their homeland (Ben-Sira, 1997). Some Iranian refugees left behind all of their assets and money over night to save their lives and those of their families. Iranian immigrants, both voluntary and involuntary, suffer from mistrust, anger, and loneliness (Good, Good, & Moradi, 1985). Iranian immigrants might be at great risk of becoming isolated, which leads them to ignore their health problems and not access health care services. Iranian refugees feel that they are living in a host country temporarily, and they hope to return to their country some day. This attitude and belief makes the acculturation process slow. But as the years pass, they recognize that this will not occur. As a result, they find that they have to accept their host country's values and norms and adjust to their new country.

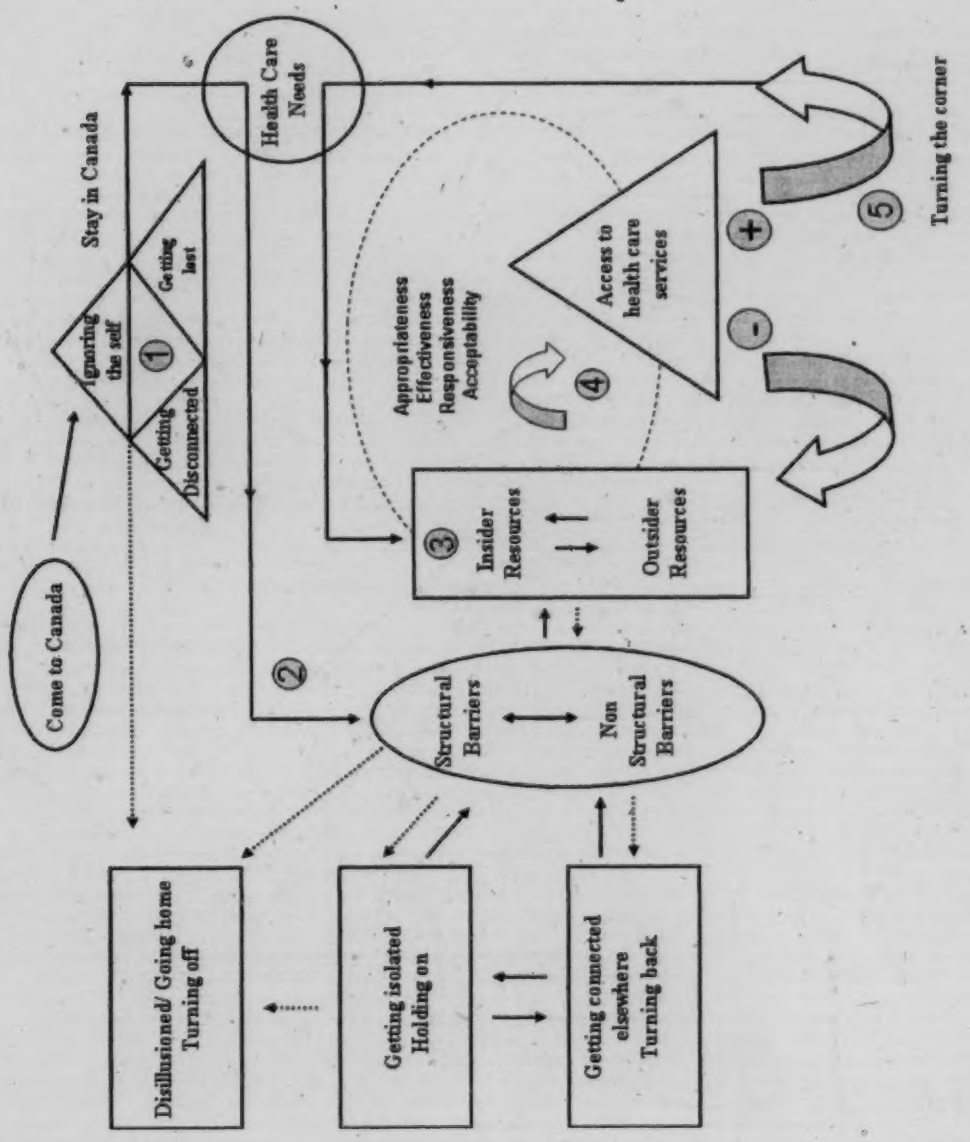
Immigrants have a hard time adjusting physically and intellectually. Intellectually, they attempt to transpose the old onto the new. They expect to find a perfect fit between what they had before and what they have now (Jones & Korchin, 1982). Goldlust and Richmonds (1974) proposed a model of the immigrant adjustment process. They believed that many variables and factors, such as individual factors (age and gender), pre-

migration experience (reason for immigration), and post-migration factors (immigration status and unemployment) interplay in immigrants' adjustment to their new societies. Acculturation of different ethnic groups occurs over different amounts of time and at different levels. Social class, background, and the individual's talent all affect the acculturation process (Greeley, 1973, Good et al., 1985, Hanassab & Tidwell, 1989, 1991 & 1993).

Although Iranians come from Iran, they are a heterogeneous group because of various factors such as the family structure, education, social class, generation of immigration, the age of immigration, and exposure to Western cultures. Although they are not the same, the most widely shared difficulties experienced by them are limited language proficiency, unfamiliarity with the host country's culture, limited economic opportunities, and discrimination (Ahearn, 2000; Elovitz & Kahn, 1997). As well, Rumbaut (1985, 1991) stated that there is a difference between voluntary and forced migration in terms of "loss" and "load" factors. Load factors are immediate and present challenges in the host countries that could be similar for both immigrants and refugees, whereas loss factors from the past are likely to be more severe for refugees. Although there are many cultural/religious groups in Iran, Iranian immigrants and refugees have "similarities of experience wrought by revolution, war, immigration, and resettlement" (Pliskin, 1992, p. 295).

In this transition, they are introduced to the culture of the host society, which is different from their own. In this chapter, I discuss the last stage of the process of Iranian immigrants accessing health care services, "becoming self-sufficient and integrated"

Figure 10. The Iranian Immigrants' Access Model to the Canadian Health Care Services (IIAMCHCS)



Note: Language emerged as central to the process of becoming self-sufficient.

(Figure 10, p. 176). In addition, I explain why some immigrants were able to move on and reach the last stage and even move further, whereas some could not and became isolated and dissatisfied with Canadian health care services. One common phenomenon among successful participants was being acculturated or bicultural. One of the issues that contributes to health disparities of immigrants is cultural differences in health care–seeking patterns generally and differences in the perception of health care services in particular (National Institute of Health, 2002).

Many studies have shown that bicultural people and individuals with a higher level of acculturation have a higher level of integration in their host countries. Szapocznik and Kutinez (1978) have pointed out that "biculturalism" has been seen as the end product of a healthy acculturation process. Integrated individuals operate effectively in their host country. Because self-sufficiency and being integrated are products of biculturalism or acculturation, I will first review briefly the literature related to the bicultural model and the acculturation model. Then, I will discuss the effects of biculturalism and acculturation on my study of Iranian immigrants accessing Canadian health care services and becoming self-sufficient.

The Bicultural Model

Ramirez (1984) defined a bicultural individual as one "with extensive socialization and life experience in two or more cultures and participates actively in these cultures" (p. 81). Ramirez added that bicultural individuals build up "an expanded behavioral repertoire including skills and knowledge from both cultures" (p. 81). In the bicultural model, immigrants see themselves in the middle ground between entirely

giving up their home culture for the host country's, on the one hand, and entirely rejecting the host culture and adhering to the home culture, on the other.

According to Ramirez and Castaneda (1974) and Solis (1981), bicultural individuals are able to function within both cultural domains, moving easily and freely from one culture to another. Research has shown a positive relationship between biculturalism and everyday functioning (Schiller, 1987). Some studies of immigrants have shown that bicultural individuals cope effectively with their native cultures and are also well-adjusted with the host cultures (LaFromboise, Coleman, & Gertan, 1993; Szapocznik, Kurtines, & Fernandez, 1980).

De Anda (1984) stated that six factors influence the degree of immigrants' biculturalism: the degree of the host and native cultures overlap with regard to norms, values, and beliefs; the presence of a cultural translator or mediator; corrective feedback to the immigrants' behavior; minority individuals' problem-solving approach; and the mesh with the styles of the majority culture.

The Acculturation Model

Although the literature is overwhelmed with various concepts and classifications to define acculturation (Berry, 1980, 1987, 1990, 1992, 1997, 2000, 2001, 2005; Broom & Eshref, 1952; Broom, Sigel, Vogt, Watson, & Barnett, 1954; Burnam, Telles, Karno, & Escobar, 1987; Ghaffarian, 1987, 1989; Keefe & Padilla, 1987; Kerendi, 1998; LaFromboise et al., 1993; Mendoza, 1989; Moghaddam & Tylor, 1987; Padilla, 1980; Redfield, Linton, & Herskovitz, 1936; Teske & Nelson, 1974), Hunt, Schneider and Comer (2004), after reviewing about 70 articles focused on Latinos' acculturation, found that 66% did not define acculturation and for those that did, their definitions of

acculturation were unclear. Bailey believed that acculturation involves the contact of at least two cultural groups, and as a result, one cultural group changes to the other. This change can happen in either one of the groups, but usually the dominant group makes the greatest contribution in this process. This definition of acculturation appears to make little or no distinction between acculturation and assimilation.

Broom and colleagues (1954) defined acculturation as a process of changing individuals' culture through the conjunction of two or more autonomous cultural systems, indicated by the selective adaptation of value systems, as well as the ability to integrate and differentiate knowledge and behavior among the cultural groups. Redfield et al. (1936) defined acculturation as "those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups" (p. 149).

Burnam et al. (1987) defined acculturation as "changes that occur in behaviors and values made by members of a culture as a result of contact with another culture" (p. 106). Moghaddam et al. (1987) described acculturation as a continuum, with assimilation (embracing the host culture and abandoning the native culture) at one end and heritage culture (keeping close to native culture as much as possible) at the other. Bicultural individuals fall somewhere in the middle of this continuum.

Acculturation has been defined as the process by which an individual adapts to a host culture that is different from the one to which he or she was born (Ghaffarian, 1987, 1989; Kerendi, 1998; Mendoza, 1989). Adaptation to a new cultural environment has been defined as an acculturation process, a dynamic and ongoing process of cultural

change that is generated at the interface of two or more cultures (Berry, 1980, 1990, 1997, 2001, 2005; Keefe & Padilla, 1987).

According to Berry (2005), acculturation is a lifelong process involving changes in many areas, such as language, behavior, cognitive style, personality, identity, and attitude. The first phase is physical or symbolic contact between two groups through education, trade, invasion, or missionary activities. This phase is considered as central and vital to acculturation. The second phase is conflict, which takes place against resistance and usually happens because groups do not want to give up valued components of their culture. The last phase is adaptation, which occurs when immigrants maintain some degree of equilibrium.

While living in a host country and experiencing new challenges, immigrants might go through different modes of acculturation. Acculturation is a multidimensional process that has a variety of subcomponents that need to be identified (Ghaffarian, 1989). It is not a linear or one-dimensional process; individuals can move back and force in the process. Acculturation involves "the modification of the person's customs, habits, language, life style, and value orientations" (Szapoczink, Scopetta, Kurtines, & Aranalde, 1978, p. 114).

Acculturation takes place when individuals' attitudes and behaviors shift from their culture of origin toward those of the dominant culture (Anderson et al., 1993; Burnam et al., 1987; Cuellar, Arnold, & Maldonado, 1995; Ghaffarian, 1987; Kerendi, 1998; Marin & Gamba, 1996; Mendoza & Martinez, 1981; Moghaddam et al., 1987; Orozco, Thompson, Kapes, & Montgomery, 1993). Clark and Hofsess (1998) believed that acculturation happens when an individual changes her or his culture through contact

with two or more cultural systems. It is a multidimensional and multicultural process in which incorporation of the beliefs and customs of an alternative culture takes place (Mendoza & Martinez, 1981).

There are three theoretical acculturation frameworks mentioned by Keefe and Padilla (1987) in their book *Chicano Ethnicity*. They defined the first model of acculturation as a linear, one-way continuum of acculturative possibilities, from unacculturation to full acculturation, with biculturalism somewhere in the middle. The linear model of acculturation is still applied to measure the level of acculturation. It suggests that an individual moves along a continuum from the culture of origin at one endpoint to the dominant culture at the other (Norris, Ford, & Bova, 1996). As individuals move along this continuum, their orientation to the culture of origin decreases while their orientation toward the dominant culture increases. To make the acculturation happen, there must be a reduction in cultural orientation in relation to the culture of origin (Elder, Apodaca, Parra-Medina, & Zuniga De Nuncio, 1998).

The second model of acculturation is called the "two culture matrix," as represented by Keefe and Padilla in 1987. In this model, individuals are classified as unacculturated, marginal, bicultural, or acculturated. Acculturated and unacculturated individuals are highly affiliated with one or another culture. Marginal individuals are not accepted by or proficient in either culture, and bicultural individuals have high acceptance and proficiency in both cultures (Keefe & Padilla, 1987).

The third model of acculturation is known as multidimensional acculturation in relation to specific traits. Multidimensional acculturation is considered selective acculturation, which allows immigrants and ethnic minorities to adopt certain strategic

traits, such as learning the official language of a host country and improving their economic status, while practicing other traditional cultural values and patterns, such as childbearing practices, music preferences, native foods and customs, and the like. In this model, some new traits might be integrated quickly and fitted into an immigrant's life, but he or she might hold onto and practice some traits from the original culture (Clark & Hofsess, 1998). Recent focus is on the bidimensional or multidimensional model more than on the linear model of acculturation. The bidimensional model views acculturation as a long-term process by which individuals learn or adapt, or both, particular aspects of the dominant culture.

The model of acculturation suggested by Berry (1987) is based on two dimensions—maintaining cultural identity and maintaining relationships with other groups in the host society—as indicators and consists of four modes of acculturation: integration, assimilation, separation or segregation, and marginalization. Individuals are considered to be integrated when their answer to both dimensions is "yes." This means that although they are willing to keep their culture, they are fully connected to the new society (Berry, 1987; Berry & Sam, 1997).

Assimilation takes place when the answer is "no" to the first dimension and "yes" to the second. As a result, individuals absorb the culture of the host country and deny their own cultural identity (Berry, 1987, 1990, 1997; Berry & Sam, 1997). Assimilation is defined as a complete integration and absorption of individuals from the old cultural system to the new. Keefe and Padilla (1987) stated that when assimilation happens, an ethnic minority group participates fully and freely in the social, economic, and political life of the mainstream society. Scholars defined three different forms of assimilation:

"homogenous assimilation," or "melting pot"; "unidirectional assimilation," or "unilateral assimilation" (Jibou, 1988); and "complete assimilation" (Broom et al., 1954). Homogenous assimilation happens when both minority and majority cultures are blended equally, whereas unidirectional assimilation occurs when the minority culture is absorbed completely into the dominant one (Jibou, 1988). Broom et al. (1954) pointed out that complete assimilation "is much less frequent in fact than is indicated by the frequency with which the term is used in the literature" (p. 988). It seems that third-generation immigrants are more likely to experience complete assimilation, as they have few ties to and little interest in any culture other than the dominant one.

Although sometimes acculturation and assimilation have been used interchangeably in the literature, they are not the same. Assimilation requires acceptance by the dominant society which is not essential for being acculturated. In contrast to acculturation, assimilation requires a favorable orientation toward the dominant culture by the acculturated individuals (Teske & Nelson, 1974). Assimilation is a unidirectional and one-dimensional linear process involving movement from one culture to the host culture to absorb cultural elements of the dominant and more desirable culture (Johnson, 1963). Following assimilation, an individual abandons identification with the home culture in favor of identification with the host culture (Olmeda, 1979).

Individuals experience separation when they persist in keeping their traditional way of life and avoid relationship with the host society (Berry, 1987; Berry & Sam, 1997). In the marginalization mode of acculturation, individuals lose contact with their traditional culture but also resist accepting the culture of the host society (Berry, 1987; Berry & Sam, 1997). Berry and Annis (1974) defined marginalization as a strategy in

which individuals lose cultural and psychological contact with both their traditional culture and the larger society and indicated that it is characterized by the individual's striking out against the larger society due to feelings of alienation, anger (Hancock, 2000) and inability to establish meaningful (personal, economic, etc.) relationships (Phinney, Horenczyk, Liebkind, & Vedder, 2001) in their host countries.

According to Mandel (1982), adaptation is the reciprocal interaction of an individual and a variety of factors involving responses to particular physical, social, and environments. Berry and Sam (1997) also identified four types of adaptation—adjustment, reaction, withdrawal, and deculturation—resulting from acculturation. In the adjustment model, to reduce the experience of conflict, the individual attempts to become more like how he or she perceives the people of the host culture to be. Adjustment is often associated with adaptation and involves changes. Adjustment happens when an individual becomes integrated into a new environment. It consists of the way one relates to others, handles responsibility, deals with stress, and satisfies one's motivations and needs (Aponte, Young, & Wohl, 1995). Many studies of adjustment of immigrants to their host countries showed that the higher the level of resistance to the new society and its culture, the higher the immigrant's adjustment difficulties (Clark & Hofsess, 1998; Ghaffarian, 1987, 1989, 1998; Griffith, 1983; Hanassab & Tidwell, 1989, 1991 & 1993 ; LaFromboise et al., 1993; Moghaddam & Taylor, 1987; Karimi Moghari, 2003; Szapocznik & Kurtinez, 1978; Szapocznik, Kurtinez, & Fernadez, 1980). Ghafarian (1998) stated,

> Iranian immigrants in the United States who adapt to the American culture while keeping their Iranian culture, as well as those who substitute their

native culture with American culture, tend to have better mental health than Iranians who resist the American culture. (p. 650)

In the reaction model, the individual abandons the host culture and tries to become involved with political organizations of his or her country of origin. In the withdrawal model, the individual minimizes contact with the host culture and might even react negatively to the mainstream culture. In the final model, the individual might experience a loss of identity, alienation, and even rebellion against the host country. Many studies have shown that acculturation facilitates immigrants' integration process in their host countries. Studies on Latino immigrant groups in the United States have indicated that people who are acculturated have fewer issues when accessing health care services (Clark & Hofsess, 1998).

Contributing Factors in Becoming Self-Sufficient

In this study acculturation or biculturalism had a positive impact on Iranian immigrants becoming self-sufficient in accessing health care services. Participants who were bicultural and acculturated had fewer difficulties accessing health care. Other studies have identified factors that affect acculturation or biculturalism, such as age, education, mental status, out-group relationship, mastery of the host country's language, and duration of residence. Studies of Iranian immigrants in the United States showed that some variables, such as educational background, age at entry into the United States, length of residence, gender (Ghaffarian, 1987, 1989; Hoffman, 1990), and level of self-esteem (Ghaffarian, 1989; Hanassab & Tidwell, 1989, 1991 & 1993) were positively related to the level of acculturation. In concurrence with the literature, Iranians participating in this study who were younger at the time of immigration, knew the

language, were educated, had previous experience of being in a country other than Iran, had not gone through traumatic events such as being in prison, tortured, or living in refugee camps for long time, and had good networks seemed to become more integrated into Canadian society and became self-sufficient.

Ansari (1988), in his study of Iranians, found four distinct patterns of behavior: the "Ambivalent Iranian," the "Persian Yankee," the "Committed Professional," and the "Self Exile." Although Ansari's study is about Iranian immigrants, as Canada is a multicultural society and people are welcome to practice their heritage as well as the Canadian lifestyle, we need to be cautious in generalizing the findings of studies involving immigrants in the United States to Canada. The Ambivalent Iranians refer to those who have intense cultural and physiological needs, prefer to maintain contact with other Iranians, and have a strong desire to return to Iran and live there. They are socially active but for the most part with families, relatives, and friends who they knew from Iran, and they have no tendency to be assimilated into the culture of host countries.

This behavioral pattern was evident in my study in participants who were isolated or were going back and forth when using resources, received help from outside of Canada, were dissatisfied with the Canadian health care services, and tried to keep their ties with families, friends or other Iranians inside and outside of Canada. Some authors have pointed out that in struggling with problems, immigrants rely on the support of family or close friends, or else they assume a passive position and try to ignore the problem (Ghaffarian, 1989; Padilla, Cervantes, Maldonado, & Garcia, 1988). Concurring with the literature, this study revealed that individuals who relied on their families, relatives, friends, or other Iranians became dependent on them and could not move on to

the next stage as quickly as those who tried to get help from mainstream resources. Therefore, they got stuck in one stage or even returned to the previous stage. According to Ansari (1988), Ambivalent Iranians are the best representatives of dual marginality and suffer from great uncertainty, conflict, and alienation.

The Persian Yankees (Ansari 1988) are those who have the least contact with other Iranians and, if they do, it is only with people who know them from work. The members of this group are the most westernized individuals and have a great deal of conflict with those Iranians who have a strong bond to the Iranian community and hope to return to Iran someday. Marriage with non-Iranians is common among these individuals, and they prefer to have relationships with Iranians who have non-Iranian spouses. According to this pattern, one participant in my study could be placed in this category. She mentioned that because of her traumatic experiences in Iran, she did not want, and still does not want, to have any connection with Iranians. Although at first she had communication problems, she preferred to get help from Canadians rather than from Iranians. She married a non-Iranian, and she mentioned that she does not bond to any particular culture but has accepted the Canadian lifestyle. She is critical of the Canadian health care system and stated that, as a Canadian, she has the right to criticize the system, the same as other Canadians.

The Committed Professionals (Ansari, 1988) are the same as the Persian Yankees regarding their relationships with other Iranians. In addition, they are more committed to their jobs than the Persian Yankees are to theirs. They distance themselves from Iranians because they make themselves super-busy with their jobs. They view assimilation as being universalized, not westernized or Americanized; therefore, they consider

themselves "citizens of the world." In my study, although a few participants were acculturated and self-sufficient regarding accessing health care services and considered themselves citizens of the world, they had great passion for helping other Iranians or newcomers from other nationalities to become self-sufficient and integrated into Canadian society in general and to access health care services in particular. Although some of them married non-Iranians, they tried to maintain connections with Iranian communities for some social activities. Participants considered this group of people as their role model for integrating quickly and effectively into Canadian society. Because these individuals have lived in Canada long enough, they know how the system works and are a great resource of reliable information. They mentioned that they came to Canada at a young age, received their degrees in English-speaking countries, and are successful citizens. They also stated that they went through the same stages as other immigrants do while they were studying outside of Iran, and they knew what it was like to be a new in a country and not know the system or the language. Therefore, based on their past experiences, they could develop good relationships with newcomers. Furthermore, other participants who received help from these individuals mentioned that they were the most reliable insider resource. Not only did they help newcomers to understand how the health care services work, but they served as their interpreters.

The last type of Iranian immigrants categorized by Ansari (1988) is called the Self Exiles, who are extensively involved with the Iranian community. Although they are not activists any more, they keep their links with the political community and consider this as "mission" and "national commitment." In my study, participants did not talk about their political stance in Canada.

As this study showed, acculturation can affect the individual seeking health care services. Language proficiency, age, cultural bonds, and social and economic contexts influence individuals' decisions to seek and use health care services (Leclere, Jensen, & Biddlecom, 1994). Participants who had communication barriers or lower levels of education or were older had to rely on informal ethnic networks. The result was a vicious circle. Because of communication barriers, they became isolated and had to maintain their ties with Iranians, and because they were isolated they did not have the chance to interact with Canadians, learn from them, and take steps toward becoming acculturated and self-sufficient. No gender differences were detected in my data.

Age

Age is considered to be one of the factors influencing Iranian immigrants in becoming self-sufficient as result of acculturation. Age, language proficiency, and bonding to culture are intertwined and affect each other directly. In my study, participants who came to Canada at a younger age or were in another country before coming to Canada at a younger age could effectively overcome barriers, reach the last stage of this process, and become acculturated and self-sufficient. This factor has been researched in different countries and among various nationalities, including Iranians.

The age of entry to a new country is important. Many studies have shown that younger immigrants are acculturated or assimilated more quickly than older immigrants (Goldlust & Richmond, 1974; Ruesch, Jacobson, & Loeb, 1984; Ghafarian, 1989; Jacob, 1994). Age at the time of immigration is very important, as the process of adjustment is influenced directly by age. Changes in life are especially difficult for older immigrants, who become isolated and lack sufficient information about the new environment (Birren

& Renner, 1980). These older individuals struggle with learning new things, such as language, driving cars, riding public transportation, and adapting to new workplaces and lifestyles. Therefore, they find themselves humiliatingly dependent on family members and friends (Ikels, 1998).

Older immigrants have more difficulty adapting to post-migration life than younger immigrants (Miller et al, 2006; Ponizovsky et al., 1998; Remennick, 2004). Younger immigrants who do not have deep roots in their own culture are more likely able to adapt to new values and lifestyles and, therefore, are more likely to become acculturated (Liang, 1994). Ghafarian (1989) found that the levels of cultural shift and cultural incorporation in younger Iranians were higher than in older individuals, whereas older Iranians were more culturally resistant. Because some Iranian immigrants rely mainly on their past experience and lifestyle in Iran, they cannot adapt and adjust to the new lifestyle, and sometimes, the process of acculturation never takes place. Therefore, they are trapped in a circle of wanting to return to Iran and not becoming acculturated. Because they are not acculturated, they cannot adapt or adjust to the new society, and so have strong feelings about returning to Iran. Participants clearly mentioned that they had to start from scratch, which was harder for older than for younger immigrants.

In this study, older Iranians showed more resistance and less integration to their new society. These findings have been supported by many studies (Beiser, Turner, & Ganesan, 1989; Mouanoutoua, Brown, Cappletty, & Levine, 1991; Mui, 1996; Westrmeyer, Callies & Neider, 1990). Ghaffarian (1998) found that age and the length of time in the United States were important in the process of acculturation. He acknowledged, "Younger Iranians had higher levels of cultural shift and cultural

incorporation and lower levels of cultural resistance than the older Iranians" (p. 649). Immigrants who had been in the United States for a shorter period had faced more adjustment issues than those who had been there for a longer time (Penaloza, 1994).

In a Canadian study, Tran (1990) reported that older individuals experience greater difficulty in language acquisition and exhibit low acculturation. Older Iranian immigrants never feel a part of mainstream Canadian culture. They do not grasp the English language, they feel isolated and alienated, and they remain dependant on their children or other family members. Participants in my study who felt isolated and did not use Canadian health care services mentioned that they do not feel like part of the mainstream Canadian culture. They trust resources outside of Canada for their health care needs.

Education and Occupation

Although age and education are intertwined factors, influencing each other, education has its own influence on the speed of the acculturation process. Occupation, having a job, and financial stability are influenced by education and have a positive impact on the process of acculturation. However, education can be considered either an advantage or a disadvantage (Westermeyer, 1989). If an immigrant's educational achievements are recognized by the host country, they are considered to be an advantage, something that helps the individual to get a job and integrate into the new country.

It has been shown that occupation can have positive impact on the acculturation process, as it facilitates entry into the host society. Immigrants with higher occupational levels generally have better education and higher income, and are more enthusiastic about

integrating into the host society than are those in low-paying jobs (Elkholy, 1985). If the expectations and ideals of well-educated migrants are not met, they are at risk for psychological crisis (Mouanoutoua et al., 1991). As a result, they become isolated. Many Iranians in exile may experience psychological distress due to poor acculturation, poor sense of control, and economic difficulties (Sundquist et al., 2000).

Most refugees leave their countries overnight and without preparation; they might even have lost their jobs and all of their credentials while they were in their own country. In these cases, it is almost impossible for them to prove their abilities and educational backgrounds. These individuals often experience depression because they end up unable to find jobs or else get low-paid employment, which is hard for them to accept. As a result, they lose their desire toward life, which, in turn, directly affects their ability to integrate into and adjust to their host country. In addition, in some cases, they even lose their desire to learn the language, which makes their situation worse. Although some participants were educated and had the potential to become integrated, they became isolated and tried to keep their ties tight with Iranians rather than involving themselves with Canadian society. To use health care services, they had to take public transportation, which was time consuming, and they had to take time off from their low-paying jobs; furthermore, they did not have work benefits or insurance coverage and so could not afford medications. All of these factors caused them to ignore their problems and led them to get help from resources outside of Canada. Therefore, their health was in danger.

Because each country has its own culture, customs, art, and lifestyles that people absorb through gradual exposure, it takes time to get involved in a new society. Partcipants who were younger and were not responsible for their families took a different

path. They tried to learn the language, making friends with Canadians and upgrading their qualifications. They mentioned that it was a long process but was worth it. They said that they realized how much they have changed since they entered Canada and how satisfied they are with Canadian health care services compared to when they arrived. This shows that age, language proficiency, and financial stability were intertwined and important factors in making decisions and using resources in accessing health care services.

Language Proficiency and Cultural Competency

In measuring acculturation, language proficiency is one of the most important and common criteria in acculturation scales (Clark & Hofsess, 1998). As mentioned earlier, age, language proficiency, and bonding to culture are intertwined and influence each other directly. Language mastery helps individuals to communicate effectively; therefore, bilingual individuals go through the process of biculturalism more easily than do individuals with language barriers. Ruesch et al. (1984) pointed out that younger immigrants appear more open to learning the language and lifestyles of the new society than older immigrants, who rely more on their experiences, which may not be compatible with the norms of their host country.

Immigrants should learn the new language if they are to function in the dominant society. However, they might feel that they are ridiculed and humiliated about their accent by the dominant members of society, which interferes with their integration into the host countries (Zambrana & Silva-Palacios, 1989). Acquiring language proficiency is one the obstacles that may be hard to overcome because of the individual's level of education or financial difficulties (Thomas, 1995).

Seeking out health care services can be affected by language barriers as well as by cultural differences. Because of unfamiliarity with the process, linguistically and culturally diverse individuals become frightened of seeking health care services or might become frustrated when faced with linguistic-cultural misunderstandings. In this study, the participants who could not move on to the last stage, became stuck at one stage, moved back to a previous stage, or became isolated all had language barriers. Therefore, they became stuck in the trap of this inability and ignored their health problems, applied self-treatment, or asked for treatment outside of Canada. These individuals were not satisfied with the Canadian services. They mentioned that because they had no power over the process of their treatment, they felt humiliated and discriminated against. Although they preferred Iranian health care services, they mentioned that hospitals, technologies, and health care providers in Canadian hospitals were much better than the public hospital system in Iran.

Nicassio (1983), in study of Indochinese refugees in the United States, found that immigrants with limited knowledge of English were likely to feel more social isolation and greater helplessness in the process of resettlement. Immigrants who had poorer English language proficiency had fewer American acquaintances and friends, and used American media less than those with a better command of English (Nicassio & Pate, 1984; Nicassio, Solomon, Guest, & McCullough, 1986). Participants in my study who reached the stage of becoming self-sufficient mentioned that one of their most reliable resources was media such as magazines, journals, TV, and the Internet. Inability to navigate new sources of information because of a lack of language and cultural competency led to isolation and alienation (Miller et al., 2006; Vinokurov, Birman, &

Trickett, 2000). Oh, Koeske, and Sales (2002), in their studies of Korean immigrants, found those with higher scores for language acculturation had lower depression scores. Kim (1988) believed that holding onto one's original language is a good indicator that an immigrant prefers to maintain the original culture.

A study of Mexicans in the United States showed that those who used Spanish-language media were less integrated than other Mexican Americans were (O'Guinn & Meyer, 1984). There is a converse relationship between the degree of ethnic communication and holding onto the original language and culture, and the degree of communication with the host society. Budman et al. (1992), in a study of Iranians in the United States, reported that the difficulties experienced most frequently by Iranians related to the English language, discrimination, cultural values, and social life. They found that transition and integration into the new lifestyle required a great deal of strength and flexibility. In a study of older Iranian immigrants in Sweden, Karimi Moghari (2003) found that because of language barriers and lack of knowledge of the Swedish health care system and social services, some immigrants experienced "more health problems than the other groups in the host country" (p. 7). Griffith (1983) hypothesized that "the more immigrants hold on to their native culture, the more they will experience adjustment difficulties" (p. 433).

Conversely, participants who did not have language barriers had different perspectives about health care services in Canada. Although some participants criticized the health care system, their concerns were about health care services in general, not specifically about immigrants and their access to services. They claimed that they knew how the system worked and stated that they had the power to obtain second, third, or

even more opinions concerning their treatment and that they often negotiated over their treatments. These individuals admired public health care services in Canada and appreciated having equal rights to services. Overall, in comparing it to health care in Iran, they preferred the Canadian health care services.

Individuals' beliefs about physical and emotional issues are always shaped by their knowledge of their culture. Immigrants face problems focusing on their physical and emotional issues as result of being torn between their beliefs and mainstream culture. Iranian refugees feel that they are living in the host country temporarily, and they hope to return to Iran someday. These attitudes and beliefs make the acculturation process slow. Iranian immigrants, both voluntary and involuntary, suffer from mistrust, anger, and loneliness (Good et al., 1985). Many of the Iranian elite, who were well educated and had to leave Iran at an older age, cannot attain the same social level that they had in Iran. They become depressed and never integrate into the new culture. Many of them talked about their nostalgic in-betweenness experience. Esmael Khoi, an Iranian poet and writer who lives in England, has described the life of Iranians in exile as living in-betweenness,

> The refugee is, and will remain *Homeless* in this sense. For him or her, everything is, and is to remain, unsettled. This is his or her predicament. The time is *Always* the time being, and *Home* a dreamland in the far far away. Un-wanting to be in the host society and un-able to go back home. Un-welcome here, and un-wanted there—except, of course, for imprisonment and/or torturing and/or shooting. An outsider here, an outcast there. Physically here, mentally there, Not a split personality, but a

> split person. The refugee is, and is to remain, the typical example of what I call "people in between" (Fathi, 1991, p. 229-230).

Acculturation is a balance between adopting and maintaining behaviors that reflect new and native cultures, and selective expression of one or the other (Willgerodt, Miller, & McElmurry, 2002). Because of differences in the culture, immigrants often do not know how to act or what is culturally acceptable (Emami, Torres, Lipson, & Ekman, 2000).

Some participants mentioned that they liked to have Iranian physicians who knew their language and culture and were also familiar with medical practices, treatments, and medications in Iran. They stated that these physicians were kind and spent time with them to listen to their problems. This finding is supported by the literature (Behjati-Sabet, 1990; Behjati-Sabet & Chambers, 2005; Dossa, 2004). Studies have shown that racially or ethnically diverse people are more satisfied with care providers from their cultural background (Barker et al., 1992; Lipson, 1992; Lavizzo-Mourey, 2002). Lavizoo-Mourey told of her experience with African American patients,

> As an African American physician, I can't tell you how many times I have met with a new African American patient who sighed with relief upon seeing me. Opened up to me when no one else could get a clear history or agreed to try a treatment because I could be trusted. (p. 12)

Some participants mentioned that because of their political background, they did not trust any Iranians and did not ask for help from them. They did not want to share their health problems and their other issues with other Iranians. According to Beeman (1976), pragmatically, in communication situations where anonymity is highly valued, one does

not expect to know the motives of the other. Mistrust is one of the important features of Iranian society. Historically, Iranians went through many changes, and to survive, they have to be very careful about exchanging information about themselves (Behjati-Sabet, 1990; Behjati-Sabet & Chambers, 2005).

Some participants mentioned that they did not really like to share and talk about their problems with others but had no choice. Although two participants had language barriers, they preferred to get help from non-Iranians because of their bad previous experience or fear of losing face in front of Iranians. Iranians almost always try to keep their honor and face and not ask a lot from others. In addition, pride (*ghorour*) led some participants who had limited knowledge of English to avoid seeking care. Iranians are culturally too proud to ask. Therefore, some participants did not ask for help, and if they did not understand the treatment, they did not ask care providers to explain it to them or initiate any negotiations. Honor and face saving are significant aspects of daily interactions. Regardless of the situation, Iranians must preserve a front for outsiders to see. They are not open to admitting failure for fear of being perceived as weak by others; they also avoid being humiliated or being criticized by others (Vreeland, 1957).

Ignoring culture can put individuals' health at risk. For instance, because Iranians like to be accepted, some might choose not to seek services and help because of fear of being rejected or misunderstood. Therefore, participants who had no language barriers mentioned that before visiting doctors, they tried to read about their problems. They mentioned that through reading, talking with others, and browsing the Internet, they tried to educate themselves. They stated that they wanted to be knowledgeable and have an active role in their treatment, because by doing this, they could negotiate more effectively

and physicians would treat them differently. Conversely, individuals who had communication barriers did not like to deal with these situations. They did not return for treatments and distanced themselves from Canadian health care services, becoming isolated and ignoring their problems.

Because of migration, individuals experience social isolation. They do not experience only physical disconnections from their native country but also separation from social interactions, obligations, and mutual rights. In experiencing social isolation, immigrants feel lonely, dissocialized, and alienated which, leads to their feeling a lack of self-confidence, so that they might not be able to initiate contact with others or maintain relationships (Kuo, 1976). In the past few years, anthropologists have noted that immigrants maintain ties with their roots even while living in host countries (Basch, & Blanc-Szanton, 1992a, 1992b). To describe this phenomenon, social scientists have used the term *transnational* (Glick Schiler, Basch, & Blanc-Szanton, 1992a). Glick Schiler and colleagues have defined transnationalism as,

> a social process in which migrants establish social fields that cross geographic, cultural, and political borders. Immigrants are understood to be transmigrants when they develop and maintain multiple relations – familial, economic, social, organizational, religious, and political – that span borders… Transmigrants take actions, make decisions, and feel concerns within a field of social relations that link together their country of origin and their country or countries of settlement. (ix-xiv)

Participating in the social and political institutions of the larger society is referred to as sociopolitical integration (Marger, 2006). It is believed that time plays an essential

role for immigrants, who are weighing the options of staying in the host country or returning back to their country of origin. Marger has suggested that it takes 8 to 18 years for immigrants to formulate their attitudes toward their host country's sociopolitical institutions and their relationship to them. If transnational ties are strong, sociopolitical integration will diminish, consequently hindering sociopolitical incorporation (Gerstle & Mollenkopf, 2001; Marger, 2006). Conversely, sociopolitical integration is accelerated in the absence of strong transnationalism (Marger, 2006). Furthermore, financial instability or limitations and lack of employment have a negative impact on transnationalism (Al-Ali, Black, & Koser, 2001; Al-Ali & Koser, 2002). Thus, if immigrants, for the aforementioned reasons, keep their ties with their communities, families, relatives, and friends in their homeland, they remain involved with their own people rather than with people in the host countries. As a result, their contributions to their host countries will be decreased, which it will delay the process of integration. My study revealed that participants who kept their ties alive with their families, relatives, and friends in Iran because of communication problems or other barriers (in Stage 2) became more involved with their own societies. Although transnationalism helped them temporarily to solve their problems in this stage, it slowed down the process of becoming integrated and self-sufficient, and hindered their access to Canadian health care services.

Those who did not get stuck in Stage 2 and moved on to the next stage went through different paths. Some chose to use insider resources to overcome barriers, and some chose external resources. For those who chose insider resources, if they happened to meet Iranians who were knowledgeable and were a great source of help, which, according to Messias (2002), could be considered transnationalism, this had positive

impact on immigrants' accessing and using health care services but not necessarily as part of the process of becoming integrated and self-sufficient. If participants happened to meet unknowledgeable Iranians, although they asked for help from their communities, they became dissatisfied with it and returned to the previous stage or tried to use external resources, even though there were communication barriers. Thus in this situation, transnationalism not only did not facilitate access to and use of health care services but also slowed down the process of becoming integrated and self-sufficient. This trial-and-error practice was an ongoing process until immigrants were successful and accessed health care services or else were unsuccessful and returned to Stage 2. However, a study involving Brazilian immigrant women regarding their transnational health resources, practices, and perspectives showed that transnationalism had a positive effect on their health practices and health care seeking; longitudinal and comparative studies are still needed if we are to understand the complexity and the nature of transnationalism (Messias, 2002).

Some participants in this study stated that they did not know what to say, what to do, or what was acceptable. They felt lost and disconnected. Because becoming self-sufficient is a product of being acculturated and bicultural, I will now discuss the effect of becoming self-sufficient in accessing and using health care services effectively and appropriately.

Becoming Self-Sufficient

By becoming self-sufficient, individuals get control of their lives. "People have always striven to control the events that affect their lives....The striving for control over life circumstances permeates almost everything people do throughout the life course

because it provides innumerable personal and social benefits." (Bandura, 1997, pp. 1-2) This study revealed that self-efficacy theory, introduced by Bandura (1969), relates to self-sufficiency. In other words, becoming self-sufficient is one of the manifestations of self-efficacy. According to Bandura (1995), "Self-efficacy is the belief in one's capabilities to organize and execute the courses of action required to manage prospective situations." (p.2) Self-efficacy refers to one's ability to perform definite behaviors in particular situations (Bandura, 1969, 1995, 1997; Elder, Apodaca, Parra-Medina, & Zuniga De Nuncio, 1998). There are four sources from which efficacy can be learned: performance accomplishments, obtaining experience and learning through observing people, verbal persuasion, and one's physiological state (Bandura, 1995, 1997; Elder et al., 1998; Baron & Byrne, 1994; Zimbardo, 1992).

The performance of accomplishments refers to personally experiencing new situations and being successful. If individuals successfully experience new situations, their self-efficacy will be increased, and vice versa. In my study, some individuals mentioned that their positive experiences of getting help from other Iranians or non-Iranians helped them in accessing health care services and got them involved with mainstream culture; others, who did not have satisfactory experiences, became isolated instead.

The second source of self-efficacy refers to observing others and considering their situations (Bandura, 1995, 1997). By doing so, individuals gain the self-confidence to deal with new situations. Many participants in this study mentioned that successful Iranians who were also willing to help and mentor them through the integration process

were one of the most important resources that helped them to continue and not give up quickly.

Verbal persuasion refers to getting a message from one who is liked, and is more persuasive than a message from someone who is disliked; therefore, the appearance, the language usage, and the quality of health care provider communication with immigrant patients and families, friends, and trusted individuals can influence self-efficacy (Bandura 1995, 1997). Participants stated that they were willing to have connection with people whom they like and to ask for help from them. Some used internal resources, some used external resources, and some used both external and internal resources.

The final factor influencing self-efficacy is one's physiological state; for example, anxiety can influence performance, resulting in an unsuccessful experience, which leads to low self-efficacy (Elder et al., 1998; Baron & Byrne, 1994; Zimbardo, 1992). By knowing the factors influencing self-efficacy, it is obvious how immigrants' self-efficacy levels can be altered and affects the process of becoming self-sufficient. In this research, I define self-sufficient individuals in general and in accessing and using health care services in particular as people who have access to information and resources, can make decision independently, have a range of options from which to make choices, are assertive and have their own voice, are interested to in making differences and helping others, and are satisfied with their contributions. Participants in my study sometimes lost their self-confidence and hope because they did not know how to act or what to do. They became exhausted by going back and forth, and by using trial and error to get services. They lost hope and ignored their problems. This affected their psychological status, and they became depressed and isolated. They became trapped in a vicious circle and lost

their self-confidence, which stopped or slowed down the process of becoming self-sufficient. Being able to access health care leads to confidence and comfort in independent access to services. It is this comfort and confidence that is the marker for becoming self-sufficient.

Summary

In conclusion, participants who came to Canada at younger ages, had international work experience, obtained their university degrees in English-speaking countries, were employed, and became bicultural or acculturated went through the stages quickly and reached the last stage. In addition, they were considered as successful role models for others and were willing to help newcomers, both Iranians and non-Iranians. They called themselves "citizens of the world" and were happy to be familiar with cultures other than their own. They mentioned that they were dancing rather than walking between two cultures. One participant, in introducing herself, quoted from Rumi, a famous Persian poet:

> I am neither Christian, nor Jew … Nor Moslem.
>
> I am not of the East, nor of the West, nor of the land, nor of the sea
>
> My place is the Placeless, my trace is the Traceless; …
>
> Neither body nor soul …
>
> I have put duality away, I have seen that the two worlds are one. (Translated by Iqbal, 1999)

In summary, this study showed that some immigrants gained victory on this battlefront and became self-sufficient, but some could not make it and stayed in different stages/phases, going back and forth, living in limbo, not satisfied and sometimes even

becoming disillusioned. This process explains why some Iranian immigrants are able to use Canadian health care services effectively while others cannot. This study showed that because of non structural and structural barriers, participants did not find Canadian health care services satisfying and trustworthy. Therefore, they delayed treatment and failed to use, misused, or overused resources and services. The main theme that emerged was that these immigrants need services that are not only accessible and appropriate but also effective, acceptable, and responsive. In the same study, participants who did not have communication barriers and were integrated into Canadian society, although they went through the same stages, overcame barriers, used resources appropriately, and found services more accessible, appropriate, effective, acceptable, and responsive. Successful integration was enhanced by acculturation. Participants in this study stated that being acculturated and integrated into Canadian society did not mean that a person should give up her or his own culture or language. It meant dancing between cultures rather than walking between them and feeling alienated or marginalized. As a result, because these people are successful, and they are from the same country and share a background and language with newcomers, they can be considered a great resource for helping new immigrants to pass through all of the stages quickly and become integrated into Canadian society. In addition, they can be good role models and examples of successful immigrants who contribute to their new country and embrace it as their own.

In the next and final chapter, I introduce a discussion of how self-sufficiency in access to health care can be fostered for Iranian, and perhaps for other, immigrants to Canada. The discussion is grounded in the finding of my study.

CHAPTER VII

LINKING LANGUAGE, INEGRATION AND ACCESS TO HEALTH CARE

The *Iranian Immigrants' Access Model to Canadian Health Care Services* (IIAMCHCS) which emerged in this study (See Figure 10, p. 176) is grounded in the data that I gained from interviewing Iranian immigrants living in Edmonton. To analyze the data, I applied constructivist grounded theory (Charmaz, 2006), as it appeared to be the most appropriate method for answering the research question. The model explains what is going on, and why; and it helps us to understand participants' meanings and their experiences of accessing health care services. While further research is needed to ascertain if the model can be used to predict health service utilization outcomes, the constructivist grounded theory method proved useful in addressing the initial research question of "What are the processes by which Iranian immigrants learn to access health care services in Canada?"

This study showed that as Iranian immigrants became better integrated into mainstream society, they also became self-sufficient in accessing health care services. Language emerged as central to the process of becoming self-sufficient. Acquisition of one of Canada's languages (English) and familiarization with mainstream norms and values were the primary strategies they used to facilitate access to health care services and integration. Participants stated that language skills led to effective communication, trust, satisfaction, integration, and self-sufficiency. Becoming self-sufficient with regard to the use of health care services helped them to integrate into the Canadian way of life. The experience of having problems accessing health care services, which in this study

emerged as so-called "Tackling the Stumbling Blocks of Access," seemed to be directly related to lack of knowledge of language, culture of mainstream society, and available services.

Being integrated helped immigrants to find their way more easily and meant that they spent less effort in adjusting to Canada. As Freire (2000) has pointed out, although becoming integrated is an ongoing process, it helps one acquire power over one's lifeworld and thus become liberated. Having power is important, because it helps people to understand, interpret, and act to shape their lives. Power, coping, adjustment to new lifestyles, integration, self-sufficiency, access, and the ability to maintain the use of health care services are intertwined. Difficulties in coping and adapting not only bar immigrants from access to and the use of health care services but also affect the health of immigrants (Coelho & Ahmad, 1980), and interfere with their becoming self-sufficient and integrated as well. What would be interesting to explore in a future study is the reciprocity that may occur as both integration and self-sufficiency in access to health care services occur. Does one precede the other, or is there a synergistic effect? If so, could development of a health care system that facilitates self-sufficiency in new immigrants accelerate integration?

Access to Health Care Services

As discussed in Chapter 2, many models of access exist. Although the model developed in this study is based on clients' experiences rather than policy-makers' or health care providers' perspectives, it is most similar to the Institute of Medicine (IOM) (Millman, 1993) access model, which features the relationship between service use and health outcomes. The IOM model suggests that structural, financial, and personal

barriers bar people from seeking health care or cause them to ignore health care providers' recommendations. It indicates that these barriers lead to a decrease and inequity in service use, resulting in poor health outcomes.

The Iranian Immigrant Access Model to Canadian Health Care Services (IIAMCHCS) is congruent with the IOM (1993) model in most respects. It does however give greater centrality to what the IOM model proposes as mediating factors (appropriateness, efficacy of treatment, quality of providers and patient adherence). While such factors do not directly affect the initiation of first contact with health care services, my research suggests that without appropriate, effective, acceptable and responsive services, patients may decide not to follow recommendations, return for follow-up, or access such services in the future. In this new model, the definition of access is expanded to include such factors. The complexity of what is actually happening is revealed in my data. Studies on health services utilization show that new immigrants are "underusers" of the health care system because of societal or cultural barriers, or because the existing services do not meet their needs (DesMeules et al., 2004). This study revealed, however, that immigrants who were struggling to access health care services sometimes misused, overused, or failed to use the provided services.

In addition, the IOM (1993) model of access is a one-way model, whereas the model proposed in this study has many feedback loops. The process reported in this study was not linear. This study showed that the ability to access health care services became a vehicle for promoting integration. The better integrated the individuals were, the better their access to health care services was.

In the Iranian Immigrant Access Model to Cananadian Health care Services proposed in this study (See Figure 10, p.176), participants who understood and spoke English were able to move through Stages 1 to 5 of gaining access to health care. They could negotiate the nonstructural (e.g., limited language proficiency) and structural (e.g., distance from clinic) barriers (Stage 2) and make their way, with the help of inside and outside resources, into health care services (Stage 3). Once they had access to these health care services, however, those participants with English language skills sometimes became frustrated with what they perceived to be poor-quality care. Given their language skills, however, they could now access other services that fit their needs better. Thus, getting the health service access alone was not the end-point. Participants with language skills could obtain care that was appropriate, acceptable, responsive, and effective with respect to their needs and perceived such care as better than the health care to which they had had access in Iran (Stage 5).

Analysis of data in my study revealed that access, maintaining the use of health care services, and becoming self-sufficient and integrated were reciprocal. Going through the process of accessing health care services and reaching the last stage not only helped immigrants meet their health needs but also helped them feel successful and satisfied. Such positive experiences affected their physical and mental health. They gained mastery in how to deal with new incidents in their lives, with health issues in particular, and with all aspects of life in their host countries in general. They became ready to get involved in their host countries. They also shared their experiences with others, and so helped others go through these stages more quickly. As they learned about barriers, future use of the right facilities was fostered, which helped them in gaining better access. The results of

this study showed that by becoming self-sufficient, Iranian immigrants did not give up their culture but instead moved back and forth between their own and the Canadian culture in a manner consistent with biculturalism. As Geiger (2001) stated, because more than ever we are dealing with diverse populations, providing culturally competent care that is free from bias is a vital responsibility for health care providers. Cultural diversity is one of the dominant attributes of Canada, and the ability of the Canadian health care system to respond to such diversity significantly influences the quality of care. Thus a definition of access to health care that encompasses the concepts of effectiveness, responsiveness, appropriateness, and acceptability appears useful if the potential of the health care system to meet the needs of the Canadian population is to be achieved.

Culturally Competent Care and Integration

There are different models and definitions of culturally competent care (Campinha-Bacote, 1994, 1995, 1998, 1999, 2003; Giger & Davidhizar, 2002; Kagawa-Singer & Blackhall, 2001; Im, Meleis, & Lee, 1999; Leininger, 1988, 1991; Papadopoulos & Lees, 2002; Purnell & Paulanka, 1998; Purnell, 2000; Tripp-Reimer, Brink, & Saunders, 1984). Cultural competence is an evolving concept; it is a new expectation in nursing that has not yet been well defined or developed (Clair & Mckenery, 1999). The term *cultural competence* was coined by Leiniger in 1991. The American Academy of Nursing (AAN) Expert Panel Report (1992) defined culturally competent care as,

> care that is sensitive to issues related to culture, race, gender, and sexual orientation. This care is provided by nurses who use cross-cultural nursing theory, models, and research principles in identifying health care needs

and in providing and evaluating the care provided. It is also care that is provided within the cultural context of the clients. (p. 277)

Cultural competence has been defined by Im, Meleis, and Lee (1999) as a "dynamic process of framing assumptions, knowledge, and meanings from a culture different than our own and a way of becoming self-aware and of understanding how meaning is assigned" (p. 455).

According to Campinha-Bacote (1997, 1999, 2003), culturally competent care includes five components; cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural awareness refers to the examination of one's own prejudices and biases against other people and their cultural background. Cultural knowledge involves learning about various cultures with the goal of understanding other people's worldview. The ability to use a culturally sensitive approach to provide and perform care is considered to be a cultural skill. Cultural encounters are interactions with clients from culturally diverse backgrounds involving culturally appropriate verbal and nonverbal communication. Cultural desire means engaging in the process of cultural competence through genuine care of and respect for clients.

Cultural competence is also operationally defined as becoming familiar with the attitudes, values, and practices of different cultures to increase the equity of health care services, improve clients' satisfaction, and provide better outcomes. Cultural competence is a critical factor in providing appropriate and effective care to diverse patient populations (Campinha-Baconte, 1994, Campinha-Bacote & Padgett, 1995; Campinha-Bacote, Yahle, & Langenkamp, 1996; Davis, 1997; Lester, 1998; Meleis, 1996, 1999).

Many scholars have defined cultural competence as the ability to function effectively with individuals of different groups through cultural awareness and sensitivity (Allegrante, Moon, Auld, & Gebbie, 2001; Marks, Reed, Colby, & Ibrahim, 2004; Papadopoulos & Lees, 2002). Papadopoulos and Lees (2002) stated that culturally competent care consists of cultural awareness, cultural knowledge, and cultural sensitivity. The National Association of Social Workers (2001) defines cultural competence as,

> The process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each. (p. 11)

To provide culturally competent care health care providers need to have good interpersonal skills, self-awareness, sensitivity, and knowledge of other cultures (Burke, 1997; Meleis, 1996). The US Office of Minority Health (OMH) pointed out in 2001, "Cultural and linguistic competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs (presented) by patients to the health care encounter" (cited in Shaw-Taylor, 2002, pp. 212-213), which improves outcomes and satisfaction. Chenowethm, Jeon, Goff and Burke (2006) believed that to provide culturally competent care, nurses should both apply strategies such as paying attention to interpersonal relationships and develop respect toward their clients and their ways of being to protect their rights and avoid the tendency to stereotype individuals from particular cultures. They also noted that nurses from other

nationalities are a great resource for the promotion of culturally competent care. Anderson and colleagues (2003) did a systematic review on culturally competent care. They stated,

> A culturally competent health care setting should include an appropriate mix of the following: a culturally diverse staff that reflect the community(ies) served; provision of translators who speak the clients' language(s); training for providers about the culture and language of the people they serve; signage and instructional literature in the clients' language (s) and consistent with their cultural norms; and culturally specific health care setting. (p. 69)

Many studies suggest that in our diverse and borderless societies, it is imperative that the health care system provide culturally competent care for immigrants who lack knowledge about language and culture (Anderson, 2004; Anderson et al., 2003; Callister, 2001; Chenowethm et al., 2006; Mullins, Blatt, Gbarayor, Yang, & Baquet, 2005; Spector, 2000; Shaw-Taylor, 2002). Some researchers did not use any particular model in their studies of culturally competent care but instead set up their own criteria for the provision of culturally competent care to the populations under their investigation (Min, 2005; Like, 2005, Poon et al., 2003, Shaw-Taylor, 2002).

In Canada, the main goal is to help newcomers to integrate into mainstream society in ways that do not require them to give up their own cultures. Integration helps immigrants to come out of their own cultural boxes and become familiar with other cultures by becoming bicultural. Because everybody is welcome to practice his or her own culture as well as the culture of Canada's society, most people are encouraged to

become more or less familiar with different cultures but are not forced to hide or give up their traditional cultures to be accepted or be successful. This stands in contrast to the situation in some countries, such as the United States, where assimilation has traditionally been the main goal and a white, English-speaking culture is dominant. In Canada, the incorporation of cultural competence has been influenced by our public health care system and our immigration policy, both of which promote integration. Although some studies have been undertaken, more work is needed to fully operationalize culturally competent care in Canada.

In addition, with respect to the notion of the global village and globalization, the world is changing. According to Freedman (2000), "One of the implications of globalization is that virtually no culture is untouched by others." (p.437). It is imperative for health care providers to understand that culture is socially constructed and changes over time. It is impossible to learn about all cultures, as they are constantly changing, but there is a simple, practical solution to this. As citizens of a global village, we have to be aware of this phenomenon and we have to be open to others' preferences and expectations rather than making assumptions based on what is usually an inadequate understanding of the manifestations of culture in specific clients. Although transnationalism is considered a product of globalization (Castles & Miller, 2003) and helps immigrants to find their way temporarily, because it keeps them close to their ties and far from interacting with mainstream host countries, it might have a negative effect on immigrants' integration in host countries and their access to health care services. As opposed to transnationalism, which keeps immigrants close to their homeland, a culturally competent health care system facilitates and encourages learning about

cultures, understanding similarities and differences among cultures, and sharing of cultures by both immigrants and their native-born counterparts.

The findings of this study have closest congruence with Anderson et al.'s (2003) concept of the culturally competent health care setting. The current findings, however, suggest that although culturally competent care is necessary for diverse, multicultural societies, health care providers should be very careful when they apply it with respect to individual clients. Brathwaite and Williams (2004) mentioned that nurses should not make assumptions about their clients use of traditional practices with respect to culture. As Callister (2001) stated, "Balancing respect for cultural beliefs and practise while maintaining professional standards of care is an art" (p. 212). In providing culturally competent care, health care providers need to be aware of cultural expectations and should know how to engage in discussions to clarify individual patient priorities. It is common for many immigrant families to engage both in practices that are embedded in their traditional cultures and in practices used in their host culture (Isajiw, 1981).

Some participants in this study mentioned that they preferred to receive the same services as other Canadians rather than being treated differently. Treating immigrants "differently", as in some models of culturally competent care, might be viewed as a strategy that indirectly facilitates marginalization and isolation rather than integration. Furthermore, some immigrants do not have a tight bond to any particular culture. Their real issues are language barriers and lack of knowledge of how the system works. They want to take the situation under their control and be able to make a decision about their life and their treatment.

Implications for Policy, Practice, Education, and Research

The findings of this study highlighted immigrants' needs for systems that are culturally competent but also enhance the immigrant's ability to acquire language skill and cultural knowledge of mainstream society. The participants in this study wanted to speak for themselves. Health care services should be tailored to facilitate this process. This means helping immigrants make decisions based on the personal significance of their historical, cultural, and social world, as individuals construct and reconstruct their reality. Each person's reality is unique, and everyone is the author of his or her own life. Individuals make health-related choices from within their own reality. Therefore, it is vital that immigrants' viewpoints be taken into account.

There is a real need for ESL services provided at different levels, depending on immigrants'/refugees' level of knowledge of English and educational background. Although some booklets and pamphlets are provided by the International Organization for Migration (IOM) to guide immigrants pre- and postimmigration and give them some information about Canada, Canadian services, how to get information, where to go for help, and what they should know, few have been translated into languages other than English. It would be helpful for immigrants to have access to this valuable information in their own language by the time of their arrival. Then, if they needed to use this information, with the help of their communities or people who know their language, they could be referred to the right services. This would prevent confusion and saves time and money, which would benefit the immigrants and perhaps reduce the costs of health care delivery.

Research indicates that newly arrived immigrants are in better health than their Canadian counterparts, but over years their health status deteriorates and they lose this advantage (Chen, Wilkins, & Ng, 1996a, 1996b). One reason that has not yet been mentioned in the literature is that they might have been sick during their first few years but because they did not seek and use health care services, there is no record of it. The fact that people do not use health care services does not necessarily mean that they are healthy. Furthermore, because immigrants enter Canada following screening tests for diseases such as tuberculosis, they believe that there is no need to focus on their health. The answer to this assertion is that these screening tests have pitfalls, such as superficial diagnostic procedures and inadequate client disclosure following a long period between the time of screening and the time of arrival (Dillmann, Pablo, & Wilson, 1995). The health care system must develop strategies that track the health of immigrants more accurately from the time of arrival in Canada. For example, a newcomer clinic to address immigrant and refugee entry health and access concerns is in the planning stage in Edmonton, Canada.

As noted by Anderson et al (2003), in order to maintain the universal accessibility of health care, providers should have broader knowledge about people and understand their differences. Having collaborative training programs, offering support through collaborative programs, and fostering cooperation among professions within the health care fields and across cultures would enhance health care providers' understanding of vulnerable populations and help the Canadian health care system become more accessible to all.

Nurses and nursing students are key providers of health care services. Since culture, language, religion, gender, beliefs, and values have a great influence on a patient's health, nurses must understand those aspects of life and use this knowledge in their patient care (Binder, 1995). In the real world, this important part of care is often ignored, and some nurses say that they are "too busy to try and understand them" (Whalen, 1999, 43).

In nursing programs, our mission is to help students apply their knowledge in a practical realm, at the community level, and as research partners, educators, and policy makers at institutional and organizational levels. Given the cultural diversity of Canada, it is important to have curriculum context about culture and its effects on health in nursing programs. Nursing programs should seek opportunities for students to work with immigrants, particularly those who have not yet acquired language skills. Although nursing has led the way in addressing disparities in health and health care, nursing leaders' effort should move beyond the beginning (Portillo, 2003) to provide better and equitable care to linguistically-culturally diverse individuals.

In addition, in harmony with reality, because Canada is a culturally diverse country, it is essential to recruit students, faculty members, and health care providers from nondominant social groups. The philosophy and ideology of academic diversity, which grew out of the civil rights movement of the 1960s and 1970s (Grant & Tate, 2001), focus on race, class, gender, ethnicity, and disability to promote equality and social justice (Grant & Sleeter, 1986). Students and faculty members should have the opportunity to examine their ideas, opinions, and even their prejudices, both through introductions to different cultures in their classrooms and through diversity in their

colleagues and peers. By doing this, before working as graduate nurses, they gain awareness of the issues and can share strategies that they applied to solve or overcome conflicts in their work with their clients or other health care providers. Students and health care providers should be taught how to help their patients, especially those who are linguistically-culturally diverse, to achieve control over their health problems, thereby actualizing "a process of helping people to assert control over the factors which affect their health" (Gibson, 1991, p. 359).

In addition, within the health care system, matching client and health care provider by language and ethnicity helps immigrants to trust, seek care, and follow their treatment. In this study, participants appreciated the idea of having an Iranian health care provider. They had no preference concerning gender, as in Iran having a male or a female physician is a matter of choice. Therefore, hiring providers who are immigrants from different countries can help linguistically-culturally diverse populations trust the health care services.

In order to provide culturally competent care to our diverse society, a diverse health care workplace is essential, as it expands access for the "underserved, foster [s] research in neglected area of societal need, and enrich[es] the pool of managers and policymakers to meet the needs of a diverse population" (Cohen, Gabriel, & Terrell, 2002, p.91). Health care professionals cannot become culturally competent by reading textbooks and listening to lectures; they have to be educated in the diverse workplace in which they will be called on to serve.

If a multicultural group wants to work together successfully, it is important that leaders establish a team representative of all cultures in the group (Stanoch, 1999). To

address the reality of a culturally diverse society in a productive way at the organizational level, managers should recruit diverse staff and provide workshops and training regarding how to work and communicate in a multicultural workplace and how to manage conflict should it arise. Cross-cultural training, by reducing misunderstandings and inappropriate behaviours, helps people to acquire both information and skills that facilitate effective cross-cultural interaction (Black & Mendenhall, 1990).

Cox (1994) introduced the Interactional Model of Cultural Diversity (IMCD). He described how the "diversity climate" of the workplace could have a positive or negative impact on the outcomes of people's careers. Employees need to understand that the core of diversity is to be able to work effectively with those who are different from them, whether other employees (Cox 2001, Gutierrez, Kruzich, Jones, & Coronado, 2000) or customers. According to Davidhizar, Dowd, and Newman (1999), cultural diversity and issues surrounding it are common in health care organizations. Wheeler (1995) claimed that diversity training is critical if a business is to be successful and productive. He pointed out,

> Paying attention to diversity will help us become more productive and better at solving problems. It will help us meet strategic goals and allow us to recruit competitively for new talent and members; cultivate a high quality work environment and positive staff morale; serve and satisfy our increasingly multicultural membership; maximize talents in the organization and minimize costs and generate more perspectives and therefore a better way to solve problems. (p. 200)

By fostering a diverse workplace and hiring people from different ethnic backgrounds, the organization will become stronger and more profitable (Thomas & Woodruff, 1999), more creative, and, in some cases, better at solving problems, which boosts productivity (Wheeler, 1995). According to Gardenswartz and Rowe (1998), effective relationships in a diverse and multicultural environment are two-way streets that require give and take and sensitivity to newcomers, so that they can learn to adapt to a culture or environment that is different from their own.

Organizations have learned that their effectiveness, success, and productivity are directly related to having diverse employees (Yamnilan & McLean, 2001). An ethnographic study of the role of physicians' transnational competence in consultations with asylum seekers in Finland showed that preparing medical students through in-services with doctors, nurses, and other clinical staff involving skills that can be applied effectively in transnational encounters – matching health care providers with immigrant/ refugee's populations– would help close disparities in certain health care outcomes (Koehn, 2006).

The Gross (1972) and Lindsay, Robins and Terrel (1999) models demonstrated that having diverse workplace and diversity training were effective tools for helping organizations in general and health care organizations in particular (Campinaha-Bacote, 1994). Employment of nurses from variety of nationalities creates a great resource for achievement of culturally competent care.

In a study at University of California aimed at offering a culturally sensitive and competent program to Latino patients (Poon et al., 2003), physicians referred all Latino paediatric orthopaedic patients to a specific clinic. The researchers did not apply any

particular model, but their goal was to provide effective care through culturally competent strategies. By matching physicians and clients for cultural and linguistic congruence, language barriers, knowledge of culture, and trust were not issues. They suggested six strategies to overcome barriers when serving clients with different languages, and from different cultures and social class. They suggested that first, physicians must show genuine interest in this group of people to form the foundation on which the other strategies are built. The second step was to research the group's background, which helped to show the health services providers' interests in learning about a group's background. The third way was to communicate with patients and open up dialogue with them. The fourth was to facilitate communication, which was considered as a key component of working with patients who are not fluent in the official language. The fifth was to identify barriers to health care that exist for a group of people. The sixth was to address barriers to health care and come up with solutions to those barriers.

Another solution is to establish community health clinics. Community health clinics (CHCs) were established during the 1970s and grew through the 1980s, but following budget cuts, the number of clinics in Ontario decreased dramatically in 1995 (Suchnigg, 2001). According to Fitch et al. (1998), one solution to this problem is to open more CHCs. They believe that smaller and more community-based institutions can help to resolve structural barriers within health care services. In their study, CHCs offered flexible visiting hours, even after-hours appointments or service over the weekend and on holidays.

Milne (2003) reported that because of these positive characteristics of CHCs, interest in opening CHCs across Canada is growing. She believes that CHC programs are successful because care is provided through teams of doctors, nurses, social workers, dieticians, and other professionals. This is a collaborative, multidisciplinary approach, which is modified to meet the needs of the community (Suschnigg, 2001). People do not need to go to one family doctor for everything. Based on their problem, clients go to a clinic and speak to a nurse, dietician, or social worker. Milne (2003) pointed out that "with physician shortages becoming dire in parts of Canada, and hospitals bursting at the seams, the hope is that collaborative care will not only improve patient access at all hours, but also reduce waiting times and improve outcomes" (p. 26). The setting and its atmosphere are more welcoming to newcomers. Suschnigg stated that, although CHC programs are not expensive and are prevention oriented, one of the obstacles to CHCs is funding difficulties in the province of Ontario. She believes that CHCs are one the most effective ways of reforming the primary health care system.

The findings of this study suggest that providing information regarding resources and services offers immigrants the opportunity to make their own decisions concerning health care services and also to take an active role in their treatment. One of the reliable resources that participants in this study appreciated the most was the public library, along with assistance from librarians, a strategy and resource which has not been mentioned in previous studies. It would be interesting to explore if this is a common strategy for immigrants from other groups. If so, libraries and librarians could get enhanced holdings and training regarding the Canadian health care system and how to

access it. A useful resource could become more attuned to specific access needs of newcomers.

Last but not least, even if health care services are committed to helping immigrants develop language skills, there will still be some occasions when an interpreter is required. In this case, medical interpreters and cultural brokers who are trained for the job, know medical terminology, and have good knowledge of the languages and cultures of both the patients and the dominant society should be employed. Although interpreters/cultural brokers and patients might be members of the same community, because they are hired by a designated organization, confidentiality is promised and patients are more likely trust to them. This would build trust and improve encounters between patients and health care providers. Because professional interpreters/cultural brokers are familiar with the cultures and languages of both patients and the dominant society, they exchange and translate as accurately as possible, which is beneficial to both patients and physicians. This affects health care services directly and, over time, is beneficial to the whole of society through the creation of a healthier population. Although the cost for the health care system to train medical interpreters and cultural brokers and create jobs for them would be high, it may be less than the cost of misdiagnosis or of not receiving treatment until a medical crisis happens, particularly for linguistic groups commonly seem in a specific health care setting. Research directed to cost-benefit analysis of such services is warranted.

This study has opened up a number of new avenues for future research. Little research has been done with respect to Iranian immigrants in Canada and their health care access issues. As a result, health care providers know little about them and tend to

consider them as similar to Arabs. Given the small amount of research on Iranian immigrants in Canada, it is hoped that this study will be followed by additional studies into the influence of acculturation on empowerment of Iranians by considering variables such as age, education, language proficiency, previous experience of living in a country other than Iran, employment, financial status, gender, external and internal support, and marital status. These studies should address the relationship between self-sufficiency and integration in more detail and in areas of Canadian society outside health care services.

Another area for research is the implementation of a program to help new immigrants quickly acquire the language skills they need to navigate daily life, including health issues. Longitudinal studies would be needed to see if those programs improved health status and integration. In addition, it may be possible to compare the response of immigrants from different cultures to the implemented programs. This would provide policy-makers with a clearer foundation from which to make decisions about new and diverse programs for immigrants in general and for specific ethnic groups in particular. Such research may also affect policy regarding funding of English as Second Language (ESL) programs, through demonstration of measurable health and integration outcomes.

Although this study showed that the issues concerning access to health care services faced by Iranian immigrants are similar to those experienced by others, comparative research involving immigrants from different countries is needed to ascertain similarities and differences. It is hoped that this study will offer some direction for all health care providers and policy makers in their efforts to provide accessible, appropriate, effective, responsive, and acceptable care to immigrants.

References

Aday, L., & Andersen, R. (1974). A framework for the study of access to medical care. *Health Services Research, 9*, 208-220.

Aday, L., & Andersen, R. (1975). *Development of indices of access to medical care*. Ann Arbor, MI: Health Administration Press.

Aday, L., & Awe, W. (1997). Health services utilization models. In D. Gochman (Ed.), *Handbook of health behavior research* (Vol. 1, pp. 153-172). New York: Plenum.

Ahearn, F. (2000). *Psychological wellness of refugees: Issues in qualitative and quantitative research*. New York: Berghahn.

Ailinger, R., & Causey, M. (1995). Health concepts of older Hispanic immigrants. *Western Journal of Nursing Research, 17*, 605-613.

Al-Ali, N., Black, R., Koser, K. (2001), *The limits to 'transnatinalism': Bosnian and Eritrean refugees in Europe as emerging transnational communities, Ethic and Racial Studies, 24*(4), 578-600.

Al-Ali, N., Koser, K. (2002). Transnationalism, international migration and home. In N. Al-Ali, & K. Koser (Eds.), *New approaches to Migranation? Transnational communities and the transformation of home* (pp. 1-15). New York: Routledge Taylor & Francis Group.

Allegrante, J. P., Moon, R. W., Auld, M. E., & Gebbie, K. M. (2001). Continuing education needs of the currently employed public health education workforce. *American Journal of Public Health, 91*, 1230-1234.

American Academy of Nursing Expert Report. (1992). Culturally competent health care. *Nursing Outlook*, *40*(6), 277-283.

Andersen, R. (1968). *A behavioral model of families' use of health services* (Research Series No. 25). Chicago: Center for Health Administration Studies, University of Chicago.

Andersen, R. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, *36*, 1-10.

Andersen, R., & Aday, L. (1978). Access to medical care in the U.S.: Realized and potential. *Medical Care*, *16*, 533-546.

Andersen, R., & Davidson, P. (2001). Improving access to care in America: Individual and contextual indicators. In R. Andersen, T. Rice, & G. Kominski (Eds.), *Changing the US health care system* (pp. 3-30). San Francisco: Jossey-Bass.

Andersen, R., Marcus, M., & Mahshigan, M. (1995). A comparative systems perspective on oral health promotion and disease prevention. In L. Cohen & H. Gift (Eds.), *Disease prevention and oral health promotion: Socio-dental sciences in action* (pp. 307-340). Copenhagen, Denmark: Muskgaard.

Andersen, R., & Newman, J. (1973). Social and individual determinants of medical care utilization. *Milbank Memorial Fund Quarterly*, *51*, 95-124.

Andersen, R., Smedby, B., & Andersen, O. (1970). *Medical care use in Sweden and the United States: A comparative analysis of systems and behavior* (Research Series No. 27). Chicago: Center for Health Administration Studies, University of Chicago.

Anderson, J. (1985). Perspectives on the health of immigrant women: A feminist analysis. *Advances in Nursing Science*, *8*(1), 61-76.

Anderson, J. (1991). Immigrant women speak of chronic illness: The social construction of the devalued self. *Journal of Advanced Nursing, 16*, 710-717.

Anderson, J. (1995). Ethnocultural communities as partners in research. In R. Masi, L. Mensah, & K. McLeod (Eds.), *Health and cultures: Exploring the relationships* (Vol. 1, pp. 319-328). New York: Mosaic.

Anderson, J. (1998). Speaking of illness: Issues of first generation Canadian women—Implications for patient education and counseling. *Patient Education and Counseling*, *33*(3), 197-207.

Anderson, K. (2004). Teaching cultural competence using an exemplar from literary journalism. *Journal of Nursing Education, 43*, 253-259.

Anderson, J., & Lynam, M. (1998). Immigrant women: Issues in health care. *Multicultural Health Bulletin*, *4*(3), 3-5.

Anderson, J., Moeschberger, M., Chen, M., Kunn, P., Wewers, M., & Guthrie, R. (1993). An acculturation scale for Southeast Asians. *Social Psychiatry and Psychiatric Epidemiology*, *28*(3), 133-141.

Anderson, J., & Reimer Kirkham, S. (1998). Constructing nation: The gendering and racialization of the Canadian health care system. In V. Strong-Boag, S. Grace, A. Eisenberg, & J. Anderson (Eds.), *Painting the maple: Essay on race, gender and the constructions of Canada* (pp. 242-261). Vancouver, Canada: University of British Columbia Press.

Anderson, J., & Rodney, P. (1999). Part IV: Conclusion—Listening to diverse voices. In H. Coward & P. Ratanakul (Eds.), *Cross cultural dialogue on health care ethics* (pp. 257-261). Waterloo, Canada: Wilfred Laurier University Press.

Anderson, L., Scrimshaw,S., Fullilove, M., Fielding, J., Normand, J. & Task Force on Community Preventive Service (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, *24*(3S), 68-79.

Anderson, J., Tang, S., & Blue. (1999). *Health systems renewal: Writing in cultural plurality*. Vancouver, Canada: Vancouver Centre of Excellence, Research on Immigration and Integration in the Metropolis.

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research*, *6*, 379-393.

Ansari, A. (1988). *Iranian immigrants in the United States: A case study of a dual marginality;* New York: Associated Faculty Press.

Aponte, J., Young, R., & Wohl, J. (1995). *Psychological interventions and cultural diversity*. Boston: Simon & Schuster.

Aroian, K. (1990). A model of psychological adaptation to migration and resettlement. *Nursing Research*, *39*, 5-10.

Aroian, K. (1993). Mental health risks and problems encountered by illegal immigrants. *Issues in Mental Health Nursing*, *14*, 379-397.

Aroian, K., & Patsdaughter, C. (1989). Multiple-method, cross-cultural assessment of psychological distress. *Image: The Journal of Nursing Scholarship*, *21*, 90-93.

Atkinson, P. (1992). *Understanding ethnographic texts*. Newbury Park, CA: Sage.

Audi, R. (1999). Self-evidence. *Philosophical Perspectives*, *13*, 205-228.

Aujlay, K. (2001). Message from the president. *Health and Culture*, *16*(1), 1.

Bagheri, A. (1992). Psychiatric problems among Iranian immigrants in Canada. *Canadian Journal of Psychiatry*, *37*, 7-11.

Bailey, A. (1937). *The conflict of European and Eastern Algonkian cultures 1504-1700: A study in Canadian civilization* (Monograph Series No. 2). St. John, Canada: New Brunswick Museum.

Baker, C., Wuest, J., & Stern, P. (1992). Method slurring: The phenomenology/grounded theory example. *Journal of Advanced Nursing*, *17*, 1355-1360.

Baker, D., Hayes, R., & Puebla-Fortier, J. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish speaking patients. *Medical Care*, *36*, 1461-1470.

Baker, D., Parker, M., Williams, K., Pitkin, W., Coates, W., & Imara, M. (1996). The health care experience of patients with low literacy. *Archives of Family Medicine*, *5*(6), 329-334.

Ballem, P. (1998). The challenge of diversity in the delivery of women's health care. *Canadian Medical Association Journal*, *159*(4), 336-338.

Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart & Winston.

Bandura, A. (1995). *Self-efficacy in changing societies*. New York: Cambridge University Press.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

Barnes, D. M. (1996). An analysis of the grounded theory method and the concept of culture. *Qualitative Health Research*, *6*, 429-441.

Baron, R., & Byrne, D. (1994). *Social psychology: Understanding human interaction.* Boston: Allyn and Bacon.

Bass, M., Looman, W., & Ehrlich, P. (1992). Predicting the volume of health and social services: Integrating cognitive impairment into the modified Anderson Framework. *The Gerontologist, 32*, 33-43.

Baxter, L., & Babbie, E. (2004). *The basics of communication research.* Menlo Park, CA: Wadsworth.

Bayne-Smith, M. (1996). Health and women of color: A contextual overview. In M. Bayne-Smith (Ed.), *Race, gender, and health* (pp. 1-42). Thousands Oaks, CA: Sage.

Becker, P. H. (1993). Common pitfalls in published grounded theory research. *Qualitative Health Research, 3*, 254-260.

Beeman, W. (1976). Iranian national character: A socio-linguistic approach. *Iranian Studies, 9*, 22-48.

Behjati-Sabet, A. (1990). The Iranians. In N. Waxler-Morrison, J. Anderson, & E. Richardson (Eds.), *Cross-cultural caring: A handbook for health professionals in Western Canada.* (pp. 91-115). Vancouver, Canada: University of British Columbia Press.

Behjati-Sabet, A., & Chambers, N. (2005). People of Iranian descent. In N. Waxler-Morrison, J. Anderson, E. Richardson, & N. Chambers (Eds.), *Cross-cultural caring* (pp. 127-162). Vancouver, Canada: University of British Columbia Press.

Beiser, M., Gill, K., & Edwards, R. (1993). Mental health care in Canada: Is it accessible and equal? *Canada's Mental Health, 41*(2), 2-7.

Beiser, M., Turner, R., & Ganesan, S. (1989). Catastrophic stress and factors affecting its consequences among Southeast Asian refugees. *Social Science & Medicine, 28*, 183-195.

Bender, D., Clawson, M., Harlan, C., & Lopez, R. (2004). Improving access for Latino immigrants: Evaluation of language training adapted to the needs of health professionals. *Journal of Immigrant Health, 6*(4), 197-209.

Ben-Sira, Z. (1997). *Immigration, stress, and readjustment.* Westport, CT: Praeger.

Berger, P., & Luckman, T. (1967). *The social construction of reality.* New York: Anchor.

Bergin, B. (1988). *Equality is the issue: A study of minority ethnic group access to health and social services in Ottawa-Carleton.* Ottawa: Social Planning Council of Ottawa-Carleton.

Berk, M., & Schur, C. (2001). The effect of fear on access to care among undocumented Latino immigrants. *Journal of Immigrant Health, 3*(3), 151-156.

Berry, J. (1980). Acculturation as varieties of adaptation. In A. Padilla (Ed.), *Acculturation: Theory, models and some new findings* (pp. 9-25). Boulder, CO: Westview.

Berry, J. (1987). Acculturation and psychological adaptation: A conceptual overview. In J. Berry & R. Annis (Eds.), *Ethnic psychology: Research and practice with immigrants, refugees, native peoples, ethnic groups and sojourners* (pp. 41-52). Kingston, Canada: Serts North America.

Berry, J. (1990). The role of psychology in ethnic studies. *Canadian Ethnic Studies, 22*, 8-21.

Berry, J. (1992). Acculturation and adaptation in a new society. *International Migration, 30*, 69-85.

Berry, J. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review, 46*(1), 5-34.

Berry, J. (2000). Socio-psychological costs and benefits of multiculturalism: A view from Canada. In J. Dacyl & C. Westin (Eds.), *Governance of cultural diversity* (pp. 297-354). Stockholm, Sweden: UNESCO & CIEFO, Stockholm University.

Berry, J. (2001). A psychology of immigration. *Journal of Social Issues, 57*(3), 615-631.

Berry, J. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*, 697-712.

Berry, J., & Annis, R. (1974). Acculturative stress: The role of ecology, culture and differentiation, *Journal of Cross-Cultural Psychology, 5*, 382-406.

Berry, J., Trimble, J., & Olmedo, E. (1986). Assessment of acculturation. In W. Lonner & J. Berry (Eds.), *Field methods in cross-cultural research* (pp. 291-324). Newbury Park, CA: Sage.

Berry, J., & Sam, D. (1997). Acculturation and adaptation. In J. Berry, M. Segall, & C. Kagitcibasi (Eds.), *Handbook of cross-cultural psychology: Social behavior and applications* (pp. 291-326). Boston: Allyn and Bacon.

Betancourt, J., Green, A., & Carrillo, J. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. New York: Commonwealth Fund.

Betancourt, J., Green, A., Carrillo, E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Heath Reports, 118*, 293-302.

Binder, V. (1995). Cultural sensitivity—do we have it? *Prairie Rose, 64*(2), 17A.

Birren, J., & Renner, V. (1980). Concepts and issues of mental health and aging. In J. Birren & V. Renner (Eds.), *Handbook of mental health and aging* (pp. 3-33). Engleside Cliffs, NJ: Prentice Hall.

Black, J., & Mendenhall, M. (1990). Cross-cultural training effectiveness: A review and a theoretical framework for future research. *Academy of Management Review, 15*(1), 113-136.

Blackford, J., Street, A., & Parsons, C. (1997). Breaking down the language barriers in clinical practice. *Contemporary Nurse, 6*(1), 15-21.

Blumer, H. (1969). *Symbolic interactionism*. Englewood Cliffs, NJ: Prentice Hall.

Bond, G. (1990). Fieldnotes: Research in past occurrences. In R. Sanjek (Ed.), *Fieldnotes: The makings of anthropology* (pp. 273-289). Ithaca, NY: Cornell University Press.

Botha, M. (1989). Theory development in perspective: The role of conceptual frameworks and models in theory development. *Journal of Advanced Nursing, 14*(1), 49-55.

Boulware, E., Cooper, L., Ratner, L., LaVeist, T., & Powe, N. (2003). Race and trust in the health-care system. *Public Health Reports, 118*, 358-365.

Boyle, J. (1989). Constructs of health promotion and wellness in a Salvadoran population. *Public Health Nursing, 6*, 129-134.

Brathwaite, A., & Williams, C. (2004). Childbirth experiences of professional Chinese Canadian women. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 33*, 748-755.

Brich, S., & Abelson, J. (1993). Is reasonable access what we want?: Implications of, and challenges to, current Canadian policy on equity in health care. *International Journal of Health Services: Planning, Administration, Evaluation, 23*(4), 629-653.

Broom, L., & Eshref, S. (1952). Mexicans in the United States: A problem in social differentiation. *Sociology and Social Research, 36*, 150-158.

Broom, L., Sigel, B., Vogt, E., Watson, J., & Barnett, B. (1954). Acculturation: An exploratory formulation. *American Anthropologist, 56*, 973-1000.

Browning, F. (2001). *Cultural barriers: Opening the doors to health care* [Special report]. Retrieved April 25, 2004, from http://www.onlinecreativeconcepts.com/healthlinks.html

Budman, C., Lipson, J., & Meleis, A. (1992). The cultural consultant in mental health care: The case of an Arab adolescent. *American Journal of Orthopsychiatry, 62*, 359-370.

Burke, D. (1997). Langauge, aging and inhibitory deficits: Evaluation of a theory. *Journal of Gerontology: Psychological Sciences, 52*, 254-264.

Burnam, A., Hough, R., Teles, C., & Escobar, J. (1987). Measurement of acculturation in a community population of Mexican-Americans. *Hispanic Journal of Behavioral Sciences, 9*(2), 105-130.

Callister, L. (2001). Culturally competent care of women and newborns: Knowledge, attitude, and skills. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 30*, 209-215.

Calman, K. (1997). Equity, poverty, and health for all. *British Medical Journal, 314*, 1187-1191.

Campinha-Bacote, J. (1994). Ethnic pharmacology: A neglected area of cultural competence. *Ohio Nurses Review, 69*(6), 10-11.

Campinha-Bacote, J. (1995). The quest for cultural competence in nursing care. *Nursing Forum, 30*(4), 19-25.

Campinha-Bacote, J. (1997). *Inventory for assessing the professional cultural competence (IAPCC) among health care professionals*. Unpublished manuscript.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education, 38*(5), 203-207.

Campinha-Bacote, J. (2003). *The process of cultural competence in the delivery of health-care services: A culturally competent model of care* (4th ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.

Campinha-Bacote, J., & Padgett, J. (1995). Cultural competence: A cultural factor in nursing research. *Journal of Cultural Diversity, 2*(1), 31-34.

Campinha-Bacote, J., Yahle, T., & Langerkamp, M. (1996). The challenge of cultural diversity for nurse educators. *Journal of Continuing Education in Nursing, 27*(2), 59-64.

Canada Health Act (2002). Retrieved December 10, 2005, from http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2002/2002_care-soinsbk4_e.html

Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. (1988). *After The Door Has Been Opened.* Ottawa: Multiculturalism and Citizenship.

Carrington, W., & Detragiache, E. (1999). How extensive is the brain drain? *Finance and Development 36(*2), 46-49. Retrieved October 20, 2006, from http://www.imf.org/external/pubs/ft/fandd/1999/06/carringt.htm

Cave, A., Maharaj, U., Gibson, N., & Jackson, E. (1995). Physicians and immigrant patients. *Canadian Family Physician, 41,* 1685-1690.

Chan, A. (1995). Transcultural health care for Chinese oncology patients. In R. Masi, L. Mensah, & K. McLeod (Eds.), *Health and cultures: programs, services and care* (pp. 121-130). Oakville, Canada: Mosaic.

Chang, P., & Fortier, J. (1998). Language barriers to health: An overview. *Journal of Health Care for the Poor and Underserved, 9,* S5-S20.

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In R. M. Emerson (Ed.), *Contemporary field research: A collection of readings* (pp. 109-126). Prospect Heights, IL: Waveland.

Charmaz, K. (1990). Discovering chronic illness: Using grounded theory. *Social Science & Medicine, 30,* 1161-1172.

Charmaz, K. (1995a). Between positivism and postmodernism: Implications for methods. In N. K. Denzin (Ed.), *Studies in symbolic interaction* (pp. 43-72). Greenwich, CT: JAI.

Charmaz, K. (1995b). Grounded theory. In J. A. Smith, R. Harré, & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 27-49). London: Sage.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 509-535). Thousand Oaks, CA: Sage.

Charmaz, K. (2002). Grounded theory: Methodology and theory construction. In N. J. Smelser & P. Baltes (Eds.), *International encyclopedia of the social and behavioral sciences* (pp. 6396-6399). Amsterdam, the Netherlands: Pergamon.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.

Charon, J. (1992). *Symbolic interactionism: An introduction, an interpretation, an integration* (4th ed.). Englewood Cliffs, NJ: Prentice Hall.

Chen, J., Wilkins, R., & Ng, E. (1996a). The health of Canada's immigrants in 1994-1995. *Health Reports*, *7*(4), 33-44.

Chen, J., Wilkins, R. & Ng, E. (1996b). Health expectancy by immigrant status. *Health Reports*, *8*(3), 29-38.

Chenowethm, L., Jeon, Y., Goff, M., & Burke, C. (2006). Cultural competency and nursing care: An Australian perspective. *International Nursing Review*, *53*, 34-40.

Cheon-Klessig, Y., Camilleri, D., McElmurry, B., & Ohlson, V. (1988). Folk medicine in the health practice of Hmong refugees. *Western Journal of Nursing Research*, *10*, 647-660.

Choudhry, U., Sirvastava, R., & Fitch, M. I. (1998). Breast cancer detection practices of South Asian women: Knowledge, attitudes, and beliefs. *Oncology Nursing Forum*, *25*(10), 1693-1701.

Chow, C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental services in poverty areas. *American Journal of Public Health*, *93*(5), 792-797.

Christensen, C. (2001). Barriers to health care for visible minority immigrant women: An examination of three communities. *Health and Cultures*, *16*(1), 4-5, 14.

Chung, R., & Kagawa-Singer, M. (1993). Predictors of psychological distress among Southeast Asian refugees. *Social Science & Medicine*, *36*, 631-639.

Chung, R., & Kagawa-Singer, M. (1995). Interpretation of symptom presentation and distress: A Southeast Asian refugee example. *Journal of Nervous and Mental Disease*, *183*, 639-648.

Citizenship and Immigration Canada. (2000). *Facts and figures 1999: Immigration Overview*. Ottawa: Minister of Public Works and Government Services Canada.

Citizenship and Immigration Canada: *Citizenship and Immigration Statistics(1966-1996)*. Retrieved December 10, 2005, from http://epe.lac-bac.gc.ca/100/202/301/immigration_statistics-ef/index.html

Citizenship and Immigration Canada: *Facts and Figures (1998-2005)*. Retrieved December 10, 2005, from http://www.cic.gc.ca/english/research/menu-fact.html

Clair, A., & McKenry, L. (1999). Preparing culturally competent practitioners. *Journal of Nursing Education*, *38*(5), 228-234.

Clark, L., & Hofsess, L. (1998). Acculturation. In S. Loue (Ed.), *Handbook of immigrant health* (pp. 37-59). New York: Plenum.

Coelho, C., & Ahmed, P. (1980). *Uprooting and development*. New York: Plenum.

Cohen, J. J., Gabriel, B. A., & Terrell, C. (2002). The case for diversity in the health care workforce. *Health Affairs, 21*(5), 90-102.

Côté, B., Colgan, J., Loiselle, C., Gastaldo, D., Semenic, S., Gendron, R., et al. (2000, June). *Allaitement maternal et marrainage en milieu pluriethnique* [Research report]. Ottawa: Health Canada.

Cox, T. (1994). *Cultural diversity in organizations: Theory, research and practice*. San Francisco: Berrett-Koehler.

Cox, T. (2001). *Creating the multicultural organization*. San Francisco: Jossey-Bass.

Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Cuellar, I., Arnold, B., & Maldonado, R. (1995). Acculturation rating scale for Mexican Americans, II: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences, 17*, 275-304.

Daniels, N. (1982). Equity of access to health care. *Health and Society, 60*(1), 51-81.

D'Avanzo, C. (1992). Bridging the cultural gap with Southeast Asians. *MCN*, 17, 204-208.

Davis, K. (1997). *Exploring the intersection between cultural competency and managed behavioral health care policy: Implications for state and county mental health agencies*. Alexandria, VA: National Teaching Assistance Center for state Mental Health Panning.

De Anda, D. (1984). Bicultural socialization: Factors affecting the minority experience. *Social Work, 29*(2), 101-107.

Dempsey, P., & Gesse, T. (1983). The childbearing Haitian refugee: Cultural applications to clinical nursing. *Public Health Reports, 98*, 261-267.

Denzin, N., & Lincoln, Y. (1994). *Handbook of qualitative research.* Thousand Oaks, CA: Sage.

Denzin, N., & Lincoln, Y. (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Department of Health and Human Services, Office of Minority Health. (2000). *Assuring cultural competence in health care: Recommendations for national standards and an outcomes-focused research agenda.* Retrieved May 10, 2006, from http://www.omhrc.gov/clas/finalcultural1a.html

Derose, K. (2000). Networks of care: How Latino immigrants find their way to and through a county hospital. *Journal of Immigrant Health, 2*(2), 79-87.

DesMeules, M., Gold, J., Kazanjian, A., Manuel, D., Payne, J., Bissandjee, B., et al. (2004). New approaches to immigrant health assessment. *Canadian Journal of Pubic Health, 95*(3), 122-126.

Didukh, G. (2001). *Health and personal care consumption patterns of Foreign-born and Canadian-born consumers: 1984-1996.* Vancouver, Canada: Vancouver Centre of Excellence, Research on Immigration and Integration in the Metropolis.

Dillmann, E., Pablo, R., & Willson, A. (1995). Patterns of health problems observed among newly arrived refugees to Canada. In R. Masi, L. Mensah, & K. McLeod,

Health and cultures: programs, services and care. (pp. 253-262). Oakville, Canada: Mosaic.

Dilmaghani, S. (1999). *Who are we?—The Iranians in Toronto today: Profile, contributions and issues*. Toronto, Canada: Family Service Association of Toronto.

Dilmaghani, S. (2001). *We are listening/Harfar ra mishenawam*. Toronto, Canada: Family Service Association of Toronto.

Documet, P., & Sharma, R. (2004). Latinos' health care access: Financial and cultural barriers. *Journal of Immigrant Health, 6*(1), 5-13.

Doherty, W., & Campbell, T. (1988). *Families and Health.* Beverly Hills, CA: Sage.

Dossa, P. (1999). *The narrative representation of mental health: Iranian women in Canada*. Vancouver, Canada: Vancouver Centre of Excellence, Research on Immigration and Integration in the Metropolis.

Dossa, P. (2001). *Narrative mediation of conventional and new paradigms of "mental health": Reading the stories of immigrant Iranian women*. Vancouver, Canada: Vancouver Centre of Excellence, Research on Immigration and Integration in the Metropolis.

Dossa, P. (2002). *Modernization and global restructuring of women's work: Border-crossing stories of Iranian women*. Vancouver, Canada: Vancouver Centre of Excellence, Research on Immigration and Integration in the Metropolis.

Dossa, P. (2004a). On social suffering: Fatima's story. In E. Cameron (Ed.), *Multiculturalism an immigration in Canada: An introductory reader* (pp. 369-393). Toronto, Canada: Canadian Scholars' Press.

Dossa, P. (2004b). *Politics and poetics of migration: Narratives of Iranian women from the Diaspora*. Toronto, Canada: Canadian Scholars' Press.

Dua, E., & Robertson, A. (Eds.). (1999). *Scratching the surface: Canadian anti-racist feminist thought*. Toronto, ON: Women's Press.

Dunn, R. (1998). *Social inequality, population health, and housing: Towards a social geography of health*. Unpublished doctoral dissertation, Simon Fraser University, Burnaby, British Columbia.

Dunn, J., & Dyck, I. (1998). *Social determination of health in Canada's immigrant population: Research from the national population health survey*. Vancouver, Canada: Vancouver Centre of Excellence, Research on Immigration and Integration in the Metropolis.

Dyck, I. (1992). Health and health care experiences of the immigrant women: Questions of culture, context and gender. *Western Geographical Series, 27*, 247-260.

Edwards, N., Ciliska, D., Halbert, T., & Pond, M. (1992). Health promotion and health advocacy for and by immigrants enrolled in English as a second language classes. *Canadian Journal of Public Health, 83*(2), 159-161.

Elder, J., Apodaca, X., Parra-Medina, D., & Zuniga De Nuncio, M. (1998). Strategies for health education: Theoretical models. In S. Loue (Ed.), *Handbook of immigrant health* (pp. 567-585). New York: Plenum.

Elkholy, A. (1985). The Arab-American family. In R. Habestein & C. Mindel (Eds.), *Ethnic families in America* (pp. 438-455). New York: Elsevier.

Elliott, J., Berman, H., & Kim, S. (2002). A critical ethnography of Korean women's menopause experience. *Health Care for Women International, 23*(4), 377-388.

Ellis, J. (1982). Southeast Asian refugee and maternity care: The Oakland experience. *Birth, 9*(3), 191-194.

Elovitz, p., & Kahn, C. (1997). Immigrant experiences. Cranberry, NJ: Associated University Press.

Emami, A., Benner, P., & Ekman, S. (2001). A sociocultural health model for late-in-life immigrants. *Journal of Transcultural Nursing, 12*(1), 15-24.

Emami, A., & Ekman, S. (1998). Living in a foreign country in old age: Senior Iranian immigrants' experiences of their social situation in Sweden. *Health Care in Later Life, 3*, 183-199.

Emami, A., Torres, S., Lipson, J., & Ekman, S. (2000). An ethnographic study of a day care center for Iranian immigrant seniors. *Western Journal of Nursing Research, 2*, 169-188.

Erzinger, S. (1991). Communication between Spanish speaking patients and their doctors in medical encounters. *Culture, Medicine and Psychiatry, 15*, 91-110.

Fadiman, A. (1997). *The spirit catches you and you fall down*. New York: Farrar, Straus and Giroux.

Falk, A. (1995). Immigrant settlement: health and social supports. In R. Masi, L. Mensah, & K. McLeod (Eds.), *Health and cultures: Exploring the relationships, programs, services and care* (pp. 307-329). Oakville, Canada: Mosaic.

Fathi, A. (1991). *Iranian refugees and exiles since Khomeini*. Costa Mesa, CA: Mazda Press.

Field, P., & Morse, J. (1985). *Nursing research: The application of qualitative approaches*. London: Croom Helm.

Fitch, M., Greenberg, M., Cava, M., Spaner, D., & Taylor, K. (1998). Exploring the barriers to cervical screening in an urban Canadian setting. *Cancer Nursing, 21*(6), 441-449.

Flaskerud, J. (1990). Matching client and therapist ethnicity, language, and gender: A review of the research. *Issues in Mental Health Nursing, 11*(4), 321-336.

Flaskerud, J., & Anh, N. (1988). Mental health needs of Vietnamese refugees. *Hospital and Community Psychiatry, 39*, 435-437.

Flores, G., Barton Lawa, M., Mayo, S., Zuckerman, B., Abreu, M., Medina, L., & Hardt, E. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics, 111*(1), 6-14.

Fowler, N. (1998). Providing primary health care to immigrants and refugees: The North Hamilton experience. *Canadian Medical Association Journal*, 4, 388-391.

Franks, F., & Faux, S. (1990). Depression, stress, mastery and social resources in four ethnocultural women's groups. *Research in Nursing and Health, 13*, 283-292.

Freedman, L. P. (2000). Human rights and women's health. In M. B. Goldman & M. C. Hatch (Eds.), *Women and health* (pp. 428-438). San Diego, CA: Academic Press.

Freire, P. (2000). *Pedagogy of the oppressed: 30th Anniversary edition*. New York: Continuum. (Original work published 1921)

Frye, B., & McGill, D. (1993). Cambodian refugee adolescents: Cultural factors and mental health nursing. *Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 6*(4), 24-31.

Gardenswartz, L., & Rowe, A. (1998). *Managing diversity: A complete desk reference and planning guide*. New York: McGraw-Hill.

Geiger, H. J. (2001). Racial stereotyping and medicine: The need for cultural competence. *Canadian Medical Association Journal*, *164*, 1699-1700.

Gerstle, G., Mollenkopf, J. (2001). The political incorporation of immigrants, then and now, In Gary Gerestle and John Mollenkopf (Eds.), *E. Pluribus Unum? Contemporary and historical perspectives on immigrant political incorporation* (pp. 1-30). New York: Russell Sage Foundation.

Ghaffarian, S. (1987). The acculturation of Iranians in the United States. *Journal of Social Psychology*, *127*(6), 565-571.

Ghaffarian, S. (1989). The acculturation of Iranian immigrants in the United States and the implications for mental health. *Journal of Social Psychology*, *138*(5), 645-655.

Ghaffarian, S. (1998). The acculturation of Iranian immigrants in the United States and the implications for mental health. *Journal of Social Psychology*, *138*, 645-654.

Gibson, C. (1991). A concept analysis of empowerment. *Journal of Advanced Nursing*, *16*(3), 354-361.

Giger, J., & Davidhizar, R. (2002).The Giger and Davidhizar transcultural assessment model. *Journal of Transcultural Nursing*, *13*, 185-188.

Glaser, B. (1978). *Advances in the methodology of grounded theory: Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

Glaser, B. (1992). *Basics of grounded theory analysis.* Mill Valley, CA: Sociology Press.

Glaser, B. (1998). *Doing grounded theory: Issues and discussion*. Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Glick Schiller, N., Basch, L., Blanc-Szanton, C. (1992a). Towards a definition of transnationalism : Introductory remarks and research questions. In N. Glick Schiller, L. Blanc-Szanton (Eds.), *Towards a transnational perspective on migration: Race, class, ethnicity, and nationalism reconsidered* (pp. ix-xiv). New York: New York Academy of Sciences.

Glick Schiller, N., Basch, L., Blanc-Szanton, C. (1992b). Transnationalism: A new analytic framework for understanding migration. In N. Glick Schiller, L. Blanc-Szanton (Eds.), *Towards a transnational perspective on migration: Race, class, ethnicity, and nationalism reconsidered* (pp. 1-24). New York: New York Academy of Sciences.

Globerman, S. (1998). *Immigration and health care underutilization patterns in Canada* (Working Paper No. 01-05). Vancouver, Canada: Vancouver Centre of Excellence, Research on Immigration and Integration in the Metropolis.

Globerman, S. (1999, October). *Policies and programs: The evolution of health for all in Canada*. Paper presented at the "Health for All" Conference, Calgary, Alberta, Canada.

Gold, M. (1998). Beyond coverage and supply: Measuring access to healthcare in today's market. *Heath Services Research, 33*, 625-652.

Goldlust, J., & Richmond, A. (1974). A multivariate model of immigrant adaptation. *International Migration Review, 8*, 193-216.

Good, B., & Good, M. (1977). The heart of what's the matter: The semantics of illness in Iran. *Culture, Medicine and Psychiatry, 1*, 25-58.

Good, B., Good, M., & Moradi, R. (1985). The interpretation of Iranian depressive illness and dysphoric affect. In A. Kleinman & B. Good (Eds.), *Culture and depression* (pp. 369-428). Berkeley: University of California Press.

Grant, C., & Sleeter, C. (1986). The literature on multicultural education: Review and analysis. *Education Review, 37*, 97-118.

Grant, C., & Tate, W. (2001) Multicultural education through the lens of the multicultural education research literature. In J. Banks & C. Banks (Eds.), *Handbook of research literature on multicultural education* (pp. 145-166). SanFrancisco: Jossey-Bass.

Greeley, A. (1973). The "religious factor" and academic careers: Another communication. *American Journal of Sociology, 78*, 1247-1255.

Griffith, J. (1983). Relationship between acculturation and psychological impairment in adult Mexican-Americans. *Hispanic Journal of Behavioral Sciences, 5*(4), 431-459.

Gross, P. (1972). Urban health disorders, spatial analysis, and the economics of health facility location. *International Journal of Health Services, 2*, 63-84.

Guba, E., & Lincoln, Y. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco: Jossey-Bass.

Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage.

Gubrium, J., & Holstein, J. (1997). *Handbook of interview research: Context and method.* Newbury Park, CA: Sage.

Guendelman, S. (1991). Health care users residing on the Mexican border: What factors determine choice of the U.S. or Mexican health care system? *Medical Care, 29,* 419-429.

Gutierrez, L., Kruzich, J., Jones, T., & Coronado, N. (2000). Identifying goals and outcome measures for diversity training: A multidimensional framework for decision-makers. *Administration in Social Work, 24*(3), 53-70.

Haffiner, L. (1992). Cross-cultural medicine—A decade later. *Western Journal of Medicine, 157*(3), 255-259.

Hafizi, H. (1998). Iranians. In J. Lipson, S. Dibble, & P. Minarik (Eds.), *Culture and nursing care: A pocket guide* (pp. 169-179). San Francisco: UCSF Press.

Hanassab, S., & Tidwell, R. (1989). Cross-cultural perspective on dating relationships of young Iranian women: A pilot study. *Counseling Psychology Quarterly, 2,* 113-121.

Hanassab, S., & Tidwell, R. (1991). Acculturation and young Iranian women: Attitudes toward sex roles and intimate relationships. *Journal of Multicultural Counseling and Development, 19,* 11-21.

Hanassab, S., & Tidwell, R. (1993). Change in the premarital behavior and sexual attitudes of young Iranian women: From Tehran to Los Angeles. *Counseling Psychology Quarterly, 6*(4), 281-289.

Hancock, Ian (2000) "The Consequences of Anti-Gypsy Racism in Europe" in *Other Voices. The (e)Journal of Cultural Criticism*, v. 2, n.1(February 2000), Retrieved October 20, 2006, from http://www.othervoices.org/2.1/hancock/roma.html

Hattar-Pollara, M., & Meleis, A. (1995). The stress of immigration and the daily lived experiences of Jordanian immigrant women in the United States. *Western Journal of Nursing Research, 17*, 521-539.

Hatton, D., & Webb, T. (1993). Information transmission in bilingual, bicultural contexts: A field study of community health nurses and interpreters. *Journal of Community Heath Nursing, 10*, 137-147.

Health and Welfare Canada. (1990). *Research priorities in multiculturalism and mental health*. Ottawa, Canada: Author.

Health Canada. (1999a). *Canadian research on immigration and health*. Retrieved January 15, 2006, from http://www.hc-sc.gc.ca/iacg-dgiac/nhrdp/

Health Canada. (1999b). *Canadian research on immigration and health*. Retrieved March 20, 2006, from http://www.hc-sc.gc.ca/iacg-dgiac/nhrdp/

Health Canada (2004). Retrieved December 10, 2005, from http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/cha-lcs-ar-ra/2003-04_e.pdf

Henry, T., & Tator, C. (1999). State policy as a racialized discourse: Multiculturalism, charter and employment equity. In P. Li (Ed.), *Race and ethnic relations in Canada* (pp. 88-155). Toronto, Canada: Oxford University Press.

Heritage Canada. (2006). *Annual report on the operation of the Canadian Multiculturalism Act*. Ottawa, Canada: Author. Retrieved October 20, 2006, from http://www.pch.gc.ca/progs/multi/reports/ann2004-2005/index_e.cfm

Hoffman, D. (1990). Beyond conflict: Culture, self, and intercultural learning among Iranians in the U.S. *International Journal of Intercultural Relations, 14*, 275-299.

Hooper, E., Comstock, L., Goodwin, J. M., & Goodwin, J. S. (1982). Patient characteristics that influence physician behavior. *Medical Care, 20*, 630-638.

Houle, L., Salmoni, A., Pong, R., Laflamme, S., & Viverais-Dresler, G. (2001). Predictors of family physician use among older residents of Ontario and an analysis of the Andersen-Newman Behavioral Model. *Canadian Journal on Aging, 20*, 233-249.

Hull, D. (1979). Migration, adaptation and illness: A review. *Social Science & Medicine, 13A*, 25-36.

Hunt, L., Schneider, S., & Comer, B. (2004). Should "acculturation" be a variable in health research?: A critical review of research on US Hispanics. *Social Science & Medicine, 59*, 973-986.

Hutchinson, S. (1986). Grounded theory: The method. In P. Munhall & C. Oiler (Eds.), *Nursing research: A qualitative perspective* (pp. 111-129). Norwalk, CT: Appleton-Century Crofts.

Hutchinson, S. A. (1993). Grounded theory: The method. In P. L. Munhall & C. O. Boyd (Eds.), *Nursing research: A qualitative perspective* (pp. 180-212). New York: National League for Nursing.

Hyman, I., & Guruge, S. (2002). A review of theory and health promotion strategies for new immigrant women. *Canadian Journal of Public Health, 93*(3), 183-187.

Ikels, C. (1998). Grandparenthood in cross cultural perspective. In M. E. Szinovacz (Ed.), *Handbook on grandparenthood* (pp. 40-52). Westport, CT: Greenwood.

Im, E., Meleis, A., & Lee, K. (1999). Cultural competence of measurement scales of menopausal symptoms: Use in research among Korean women. *International Journal of Nursing Studies, 36*, 455-463.

Institute of Medicine. (1993). *Access to health care in America*. Washington, DC: National Academy.

Iqbal, A. (1999). *The life and work of Jalaludin Rumi*. Karachi, Pakistan: Oxford University Press.

Isajiw, W. (1981). *Ethnic identity retention in Toronto*. Toronto, Canada: Centre for Urban and Community Studies, University of Toronto.

Ivanov, L., & Buck, K. (2002). *Journal of Immigrant Health, 4*(1), 17-27.

Jackson, C. (1998). Medical interpretation. In S. Loue (Ed.), *Handbook of immigrant health* (pp. 61-79) New York: Plenum.

Jacob, A. (1994). Social integration of Salvadoran refugees. *Social Work, 39*(3), 307-312.

Jalali, B. (1982). Iranian Families. In M. McGoldrick, J. Pearce, & J. Giordano, *Ethnicity and family therapy* (pp. 289-309). New York: Guilford.

Jezewski, M. (1989). Using a grounded theory method to develop a model of culture brokering in a migrant farmworker health care setting. *DAI-A*, *50*(6), 1713, 287.

Jezewski, M. (1990). Culture brokering in migrant farm worker health care. *Western Journal of Nursing Research*, *12*(4), 497-513.

Jezewski, M. (1993a). Acting as a culture broker for culturally diverse staff, *Patient Care Management*, *8*(10), 6-8.

Jezewski, M. (1993b). Culture brokering as a model for advocacy, *Nursing & Health Care*, *14*(2), 78-85.

Jezewski, M. (1993c). Nurse executives as culture brokers: A model for addressing diversity. *Patient Care Management*, *8*(9), 3-4.

Jibou, R. M. 1988. Ethnic hegemony and the Japanese in California. *American Sociological Review*, 53, 353-367.

Johnston, R. (1963). A new approach to the meaning of assimilation. *Human Relations*, *16*, 295-298.

Jones, C. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*, *90*(8), 1212-1215.

Jones, E., & Korchin, S. (1982). Minority mental health perspectives. In E. Jones & S. Korchin (Eds.), *Minority mental health* (pp. 3–36). New York: Praeger.

Jourdain, A. (2000). Equity of a health system. *European Journal of public Health*, *10*(2), 138-142.

Juarbe, T. (1995). Access to health care for Hispanic women: A primary health care perspective. *Nursing Outlook*, *43*(1), 23-28.

Kagawa-Singer M., & Blackhall, L. (2001). Negotiating cross-cultural issues at the end of life: "You got to go where he lives." *Journal of the American Medical Association, 286*, 2993–3002.

Karimi Moghari, F. (2003). Elderly wellbeing: A comparative study between aged ethnic Iranians and native Swedes. *Shiraz E-Medical Journal, 4*(4). Retrieved January 20, 2004, from http://semj.sums.ac.ir.

Karmi, G. (1991). The health status and health beliefs of two London migrant communities. *International Migration, 29*(1), 5-12.

Katz, D., & Gagnon, A. (2002). Evidence of adequacy of postpartum care for immigrant women. *Canadian Journal of Nursing Research, 34*(4), 71-81.

Kaufert, J., & Koolage, W. (1984). Role conflict among cultural brokers: The experience of native Canadian medical interpreters. *Social Sciences & Medicine, 18*(3), 283-286.

Kaufert, J., & O'Neil, J. (1990). Biomedical rituals and informed consent: Native Canadians and the negotiation of clinical trust. In G. Weisz (Ed.), *Social science perspectives on medical ethics* (pp. 41- 64). Philadelphia: University of Pennsylvania Press.

Kaufert, J., O'Neil, J., & Koolage, W. (1985). Culture brokerage and advocacy in urban hospitals: The impact of native language interpreters. *Santé Culture Health, 2*(3), 3-9.

Kaufert, J., & Putsch, R. (1997). Communication through interpreters in healthcare: Ethical dilemmas arising from differences in class, culture, language and power. *Journal of Clinical Ethics, 8*, 71-87.

Keefe, S., & Padilla, A. (1987). *Chicano ethnicity*. Albuquerque: University of New Mexico Press.

Kerendi, F. (1998). *Acculturation and gender roles attitudes as related to acculturative stress in Iranian immigrant women*. Unpublished doctoral dissertation, California School of Professional Psychology, Los Angeles.

Khan, A., & Bhardwaj, S. (1994). Access to health care: A conceptual framework and its relevance to health care planning. *Evaluation and the Health Professions, 17*, 60-76.

Kim, S. (1988). Family therapy for Americans: A strategic structural framework. *Psychotherapy, 22*, 343-348.

King, G., & Williams, D. (1996). Race and health: A multidimensional approach to African-American health. In B. Amick, S. Levine, A Tarlov, & D. Walsh (Eds.), *Society and Health* (pp. 93-130). New York: Oxford University Press.

Kipfer, A (Ed.). (2006). Roget's New Millennium™ Thesaurus (1st ed., V 1.3.1). Lexico Publishing Group, LLC.

Kleinman, A. (1988). *The illness narratives: Suffering, healing and the human condition*. New York: Basic Books.

Koehn, P. (2006). Globalization, migration health, and educational preparation for transnational medical encounters. Globalization and Health, 2(2), Retrieved October 20, 2006, from http://www.globalizationandhealth.com/content/2/1/2

Kronenfeld, J. (1980). Sources of ambulatory care and utilization models. *Health Services Research, 15*, 3-20.

Kulig, J. (1990). A review of the health status of Southeast Asian refuges women. *Health Care for Women International*, *11*, 49-63.

Kulig, J. (1995). Cambodian refugees' family planning knowledge and use. *Journal of Advanced Nursing*, 22, 150-157.

Kuo, W. (1976). Theories of migration and mental health: An empirical testing of Chinese-Americans. *Social Science & Medicine*, *10*, 297-306.

LaFromboise, T., Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin*, *114*, 395-412.

Laurence, R. (1992a). Part I: Torture and mental health—A review of the literature. *Issues in Mental Health Nursing*, *13*, 301-310.

Laurence, R. (1992b). Part II: The treatment of torture survivors—A review of the literature. *Issues in Mental Health Nursing*, *13*, 311-320.

Lautard, G., & Guppy, N. (1999). Revisiting the vertical mosaic: Occupational satisfaction among Canadian Ethnic Groups. In P. Li (Ed.), *Race and ethnic relations in Canada* (pp. 219-252). Toronto, Canada: Oxford University Press.

Lavizzo-Mourey, R. (2002). *Unequal treatment: Confronting racial and ethical disparities in health care*. Washington, DC: National Academies Press, Institute of Medicine. Retrieved June 20, 2002, from http://www.iom.edu/topic.asp?id=18007

Leclere, F., Jensen, L., & Biddlecom, A. (1994). Health care utilization, a family context, and adaptation among immigrants to the United States. *Journal of Health and Social Behavior*, *35*(13), 370-384.

Leduc, N., & Proulx, M. (2004). Patterns of health services utilization. *Public Health Nursing, 21*(5), 412-418.

Lee, J., Pulvino, C., & Perrone, P. (1993). *Dynamic counseling*. Madison, WI: Instructional Enterprises.

Lee, K. (2000). *Urban poverty in Canada*. Retrieved April 10, 2000, from http://www.ccsd/ca

Lee, M., & Herrera, M. (1995). A changing city: The response of the City of Toronto Department of Public Health. In R. Masi, L. Mensah & K. McLeod (Eds.), *Health and cultures* (pp. 63-70). Oakville, Canada: Mosaic.

Lee, R. (1994). Passage from the homeland. *Canadian Nurse, 90*(9), 27-32.

Leininger, M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. *Nursing Science Quarterly, 1*, 152-160.

Leininger, M. (1991). *Culture care diversity and universality: A theory of Nursing*. New York: NLN.

Lester, N. (1998). Cultural competence: A musing dialogue. *American Journal of Nursing, 98*(8), 26-33.

Liang, Z. (1994). Social contact, social capital, and the naturalization process: Evidence from six immigrant groups. *Social Science Research, 23*, 407-437.

Like, R. (2005). Culturally competent family medicine: Transforming clinical practice and ourselves. *American Academy of Family Physicians,72*(11), 2267-2274.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lindsay, R., Robins, K., & Terrel, R. (1999). *Cultural Proficiency: A manual for school administrators*. Thousand Oaks, CA: Corwin Press.

Lipson, J. (1991). Afghan refugee health: Some findings and suggestions. *Qualitative Health Research, 1*, 349-369.

Lipson, J. (1992). The health and adjustment of Iranian immigrants. *Western Journal of Nursing Research, 1*, 10-24.

Lipson, J. (1993). Afghan refugees in California: Mental health issues. *Issues in Mental Health Nursing, 14*, 411-423.

Lipson, J. (1999). Cross-cultural nursing: The cultural perspective. *Journal of Transcultural Nursing, 10*(1), 6.

Lipson, J., Hosseini, T., Kabir, S., Omidian, P., & Edmonston, F. (1995). Health issues among Afghan women in California. *Health Care for Women International*, 16, 279-286.

Lipson, J., & Meleis, A. (1983). Issues in health care of Middle Eastern patients. *Western Journal of Medicine, 139*, 854-861.

Lipson, J., & Meleis, A. (1985). Culturally appropriate care: The case of immigrants. *Topics in Clinical Nursing, 7*, 48-56.

Lipson, J., & Meleis, A. (1999). Research with immigrants and refugees. In A. Hinshaw, S. Feetham, & J. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 87-106), Thousand Oaks, CA: Sage.

Lipson, J., & Miller, S. (1994). Changing roles of Afghan refugee women in the U.S. *Health Care for Women International, 14*, 171-180.

Litman, T., & Venters, M. (1979). Research on health care and the family. *Social Science & Medicine, 13A*, 379-385.

Litwin, H. (1997). The network shifts of elderly immigrants: The case of Soviet Jews in Israel. *Journal of Cross-Cultural Gerontology*, *12*(1), 45-60.

Loiselle, C., Semenic S., Côté, B., Lapointe, M., & Gendron, R. (2001). Impressions of breastfeeding information and support among first-time mothers within a multiethnic community. *Canadian Journal of Nursing Research*, *33*(3), 31-46.

Lowenberg, J. S. (1993). Interpretive research methodology: Broadening the dialogue. *Advances in Nursing Science*, *16*(2), 57-69.

Lynam, M. (1985). Support networks developed by immigrant women. *Social Science & Medicine*, *31*, 327-333.

MacKinnon, M., Howard, L., & Larkin, F. (1998). Immigrant women on the topic of health: A preliminary report on the Prince Edward Island Maritime Centre for Excellence in Women's Health Project. *Health and Cultures*, *13*(2), 1, 4.

Mandel, G. (1982). Mental health and the Native American: Responding to the challenge of the biopsychosocial model. *White Cloud Journal*, *3*, 43-51.

Marin, G., & Gamba, R. (1996). A new measurement of acculturation for Hispanics: The bidimensional acculturation scale for Hispanics (BAS). *Hispanic Journal of Behavioral Sciences*, *18*(3), 297-316.

Maines, D. (1993). Narrative's moment and sociology's phenomena: Toward a narrative sociology. *Sociological Quarterly*, *34*, 17-38.

Manson, A. (1988). Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. *Medical Care*, *26*, 1119-1128.

Marger, M. (2006). *Transnationalism or assimilation? Patterns of socio-political adaptation among Canadian business immigrants, Ethic and Racial Studies, 29*(5), 882-900.

Markland, S., & Turnbull, G. (1995). Immigrant settlement: health and social supports. In R. Masi, L. Mensah, & K. McLeod (Eds.), *Health and cultures: Exploring the relationships programs, services and care.* (pp. 59-78). Oakville, Canada: Mosaic.

Marks, J., Reed, W., Colby, K., & Ibrahim, S. A. (2004). Culturally competent approach to cancer news and education in an inner city community: Focus group findings. *Journal of Health Communication, 9*, 143-157.

Marshall, P., Koenig, B., Grifhorst, P., & Ewijk, M. (1998). Ethical issues in immigrant health care and clinical research (pp. 203-226). In S. Loue (Ed.), *Handbook of immigrant health* (pp. 203-226). New York: Plenum.

Matherlee, K., & Burke, N. (1997). Cross-cultural competency in a managed-care environment. *National Health Policy Forum Issues Brief, 705*, 1-13.

Masi, R., Mensah, L., & McLeod, K. (1995). *Health and cultures: Policies, professional practice and education.* Oakville, Canada: Mosaic.

Masi, R., Mensah, L., & McLeod, K. (1996). *Health and cultures: Programs, services and care.* Oakville, Canada: Mosaic.

Mautner, T. (1999). *The Penguin dictionary of philosophy*. London: Penguin.

May, K. (1992). Middle Eastern immigrant parents' social networks and help-seeking for child health care. *Journal of Advanced Nursing, 17*, 905-912.

McCracken, G. (1988). *The long interview*. Newbury Park, CA: Sage.

McKinlay, J. (1975). Some issues associated with migration, health status, and the use of human services, *Journal of Chronic Disease*, *28*, 579-592.

Mead, G. (1962). *Mind, self and society*. Chicago: University of Chicago Press.

Meadows, L., Thurston, W., & Melton, C. (2001). Immigrant women's health. *Social Science & Medicine*, *52*(9), 1451-1458.

Mechanic, D. (1979). Correlates of physician utilization: Why do major multivariate studies of physician utilization find trivial psychosocial and organization effects? *Journal of Health and Social Behavior*, *20*, 387-396.

Meleis, A. (1991). Between two cultures: Identity, roles and health. *Health Care for Women International*, *12*(3), 365-377.

Meleis, A. (1996). Culturally competent scholarship: Substance and rigor. *Advanced Nursing Science*, *19*(2), 1-16.

Meleis, A. (1999). Culturally competent care. *Journal of Transcultural Nursing*, *10*(1), 12.

Meleis, A., Lipson, J., & Paul, S. (1992). Ethnicity and health among five Middle Eastern immigrant groups. *Nursing Research*, *41*, 98-103.

Meleis, A., Omidian, P., & Lipson, J. (1993). Women's health status in the United States: An immigrant women's project. In J. Beverly, K. McElmury, F. Norr, & R. Parker (Eds.), *Women's health and development: A global challenge* (pp. 163-181). Boston: Jones and Bartlett.

Mendoza, R. (1989). An empirical scale to measure type and degree of acculturation in Mexican American adolescents and adults. *Journal of Cross-Cultural Psychology*, *20*, 372-385.

Mendoza, R., & Martinez, J. (1981). The measurement of acculturation. In A. Baron (Ed.), *Explorations in Chicano psychology* (pp. 71-82). New York: Praeger.

Messias, D. (2002). Transnational health resources, practices, and perspectives: Brazilian immigrant women's narratives. *Journal of Immigrant Health 4*(4), 183-200.

Miller, A., Sorokin, O., Wang, E., Feetham, S., Choi, M., & Willbur, J. (2006). Acculturation, social alienation and depressed mood in midlife women from the former Soviet Union. *Research in Nursing & Health, 29*(2), 134-146.

Millman, M. (1993). *Access to health care in America.* Washington, DC: National Academy Press.

Milne, C. (2003, June 16). Team players: Doctors, nurses, and other health workers are embracing a collaborative approach. *Maclean's Magazine*, pp. 26-30.

Min, J. (2005). Cultural competency: A key to effective future social work with racially and ethnically diverse elders. *Families in Society: The Journal of Contemporary Social Services, 86*(3), 347-358.

Moghaddam, F., Taylor, M., & Lalonde, N. (1987). Individualistic and collective integration strategies among Iranians in Canada. *International Journal of Psychology, 22*, 301-313.

Morris, M., Ogilvie L., Fung M., Lau A., Ong A., & Boyd J. (1999). Cultural brokering in community health. *Canadian Nurse, 6*, 28-32.

Morse, J. (1991). Negotiating commitment and involvement in the patient-nurse relationship. *Journal of Advanced Nursing, 16*, 455-468.

Morse, J. M. (2001).Situating grounded theory within qualitative inquiry. In R. Schreiber & P. Stern, *Using grounded theory in nursing* (pp. 1-15). New York: Springer.

Morse, J., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, *1*(2). Article 2. Retrieved Dec 10, 2005 from http://ualberta.ca/~ijqm/

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals.* Thousand Oaks, CA: Sage.

Morse, J., & Richardson, L. (2002). *Readme first for a user's guide to qualitative methods*. Thousand Oaks, CA: Sage.

Mouanoutoua, V., Brown, L., Cappelletty, G., & Levine, R. (1991). A Hmong adaptation of the Beck Depression Inventory. *Journal of Personality Assessment, 57*, 309-322.

Muecke, M. (1990). *Bibliography: Nursing research and practice with refugees* (Southeast Asian Refugee Studies, Occasional Papers No. 10). Minneapolis: Southeast Asian Refugee Studies Project, University of Minnesota.

Muecke, M., & Sassi, L. (1992). Anxiety among Cambodian refugee adolescents in transit and in resettlement. *Western Journal of Nursing Research, 14*, 267-291.

Mui, A. (1996). Depression among elderly Chinese immigrants: An exploratory study. *Social Work, 41*, 633-645.

Mullins, C., Blatt, L., Gbarayor, C., Yang, H., & Baquet, C. (2005). Health disparities: A barrier to high-quality care. *American Journal of Health-System Pharmacy, 62*, 1873-1882.

Nakhaie, R. (1999). Vertical mosaic among the elites: The new imagery revisited. In R. Nakhaie (Ed.), *Debates on social inequality: Class, gender and ethnicity in Canada* (pp. 264-278). Toronto, Canada: Harcourt, Brace and Company.

National Association of Social Workers. (2001). NASW *standards for cultural competence in social work practice.* Washington, DC: Author.

National Institute of Health. (2002). *Addressing health disparities: The NIH program of action.* Retrieved March 20, 2004, from http:// www.healthdisparities.nih.gov/whatare.html

Nerad, S., & Janczur, A. (2000). *Primary health care with immigrant and refugee populations: Issues and challenges*. Paper presented at the 2nd International Conference Primary Health Care 2000, Melbourne, Australia in April 2000.

Neufeld, A., Harrison, M., Stewart, M., Hughes, K., & Spitzer, D. (2002). Immigrant women: Making connections to community resources for support in family caregiving. *Qualitative Health Research, 12*, 751-768.

Nicassio, P. (1983). Psychological correlates of alienation: The study of a sample of Indochinese refugees. *Journal of Cross-Cultural Psychology, 14*, 337-351.

Nicassio P., & Pate, J. (1984). An analysis of problems of resettlement of the Indochinese refugees in the United States. *Social Psychiatry, 19*, 135-141.

Nicassio, P., Solomon, G., Guest, S., & McCullough, J. (1986). Emigration stress and language proficiency as correlates of depression in a sample of Southeast Asian refugees. *International Journal of Social Psychology, 32*, 22-28.

Norris, A. E., Ford, K., & Bova, C. A. (1996). Psychometrics of a brief acculturation scale for Hispanics in a probability sample of urban Hispanic adolescents and young adults. *Hispanic Journal of Behavioral Sciences, 18*, 29-38.

O'Guinn, T., & Meyer, T. (1984). Segmenting the Hispanic market: The use of Spanish language radio. *Journal of Advertising Research, 23*, 9-16.

Oh, Y., Koeske, G., & Sales, E. (2002). Acculturation, stress, and depressive symptoms among Korean immigrants in the United States. *Journal of Social Psychology, 142*(4), 511-526.

Olmeda, E. (1979). Acculturation: A psychometric perspective. *American Psychologist, 34*, 1061-1070.

Omidian, P., & Lipson, J. (1996). Ethnic coalitions and public health: Delights and dilemmas with the Afghan Health Education project in Northern California. *Human Organizations, 55*, 355-360.

Orozco, S., Thompson, B., Kapes, J., & Montgomery, G. (1993). Measuring the acculturation of Mexican Americans: A covariance structure-analysis. *Measurement and Evaluation in Counseling and Development, 25*, 149-155.

O'Shea, M. (2000). *Culture shock: Iran*. Portland, OR: Graphic Arts Centre.

Padilla, A. (1980). The role of cultural awareness and ethnic loyalty in acculturation. In A. Padilla (Ed.), *Acculturation: Theory, models, and some new findings* (pp. 47-83). Boulder, CO: Westview.

Padilla, A., Cervantes, R. Maldonado, M., & Garcia, R. (1988). Coping responses to psychosocial stressors among Mexican and Central American immigrants. *Journal of Community Psychology, 16*(1), 13-32.

Papadopoulos, I., & Lees, S. (2002). Developing culturally competent researchers. *Journal of Advanced Nursing, 37*(3), 258-264.

Pappas, G. (1990). Some implications for the study of the doctor-patient interaction: Power, structure, and agency in the works of Howard Waitzkin and Arthur Kleinman. *Social Science & Medicine, 30*(2), 199-204.

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care, 8*(5), 491-497.

Park, K., & Peterson, L. (1991). Beliefs, practices, and experiences of Korean women in relation to childbirth. *Health Care for Women International, 12*, 261-269.

Parikh, N. (2003, Dec 24). The language barrier: An unbridged communication gulf keeps immigrants from getting good health care. *Orange County Register*, 5-9.

Parse, R. (2001). *Qualitative inquiry: The path of sciencing*. Boston: Jones and Bartlett.

Patton, M. (2002). *Qualitative research and evaluation methods*. Thousands Oaks, CA: Sage.

Penaloza, L. (1994). Atravensando fronteras/border crossing: A critical ethnographic exploration of the consumer acculturation of Mexican immigrants. *Journal of Consumer Resaerch, 21*(June), 32-45.

Penchansky, R. (1977). *The concept of access: A definition*. Hyattsville, MD: National Health Planning Information Center.

Penchansky, R., & Thomas, J. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care, 19*(2), 127-140.

Perez, T. (2001). Health and civil rights. *Cancer, 9*(1), 217-220.

Pescosolido, B., & Kronenfeld, J. (1995). Health, illness, and healing in an uncertain era: Challenges from and for medical sociology. *Journal of Health and Social Behavior, 5*(Special Issue), 5-33.

Phinney, J., Horenczyk, G., Liebkind, K., & Vedder, P. (2001). Ethnic identity, immigration, and well-being: An interactional perspective. *Journal of Social Issues, 57*(3), 493-510.

Pickwell, S. (1996). Providing health care to refugees. *Advanced Practice Nursing Quarterly, 2*(2), 39-44.

Pinderhughes, E. (1989). *Understanding race, ethnicity, and power: The key to efficacy in clinical practice*. New York: Free Press.

Pliskin, K. (1987). *Silent boundaries: Cultural constraints on sickness and diagnosis of Iranians in Israel.* New Haven, CT: Yale University Press.

Ponizovsky, A., Ginath, Y., Durst, R., Wondimeneh, B., Safro, S., Minuchin-Itzigson, S., et al. (1998). Psychological distress among Ethiopian and Russian Jewish immigrants to Israel: A cross-cultural study. *International Journal of Social Psychiatry, 44*, 35-45.

Poon, A., Gray, K., Franco, G., Cerruti, D., Schreck, M., & Delgado, E. (2003). Cultural competence: Serving Latino patients. *Journal of Pediatric Orthopaedics, 23*, 546-549.

Porter, E. (2000). Research on home care utilization: A critical analysis of the pre-eminent approach. *Journal of Aging Studies, 14*, 25-38.

Portes, A., Kyle, D., & Eaton, W. (1992). Mental illness and help-seeking behaviour among Mariel Cuban and Haitian refugees in South Florida. *Journal of Health and Social Behavior, 33*, 283-298.

Portillo, C. (2003). Health disparities and culture—Moving beyond the beginning, *Journal of Transcultural Nursing, 14*(1), 5.

Purnell, L. (2000). A Description of the Purnell model for cultural competence. *Journal of Transcultural Nursing, 11*(1), 40-46.

Purnell, L., & Paulanka, B. (1998). Transcultural diversity and health care. In L. Purnell & B. Paulanka (Eds.), *Transcultural health care* (pp. 323- 351). Philadelphia: F. A. Davis.

Putsch, G. (1985). Cross-cultural communication: The special case of interpreters in health care. *Journal of the American Medical Association, 254*(23), 3344-3348.

Pyke, J., Morris, L., & Sabriye, A. (2001). Improving accessibility: The experience of a Canadian mental health agency. *Psychiatric Rehabilitation Journal, 25*(2), 180-185.

Ramirez, M. (1984). Assessing and understanding biculturalism-multiculturalism in Mexican-American adults. In J. Martinez & R. Mendoza (Eds.), *Chicano psychology* (2nd ed., pp. 77-94). New York: Academic Press.

Ramirez, M., & Castaneda, A. (1974). *Cultural democracy, bicognitive development and education*. New York: American Press.

Ramsden, I. (1993). *Korero whakaruruhau: Phase one of a qualitative research project into culturally acceptable standards of health service delivery to Maori.* Wellington, Australia: Author.

Ramsden, I. (2000). Cultural safety/ Kawa whakaruruhau ten years on: A personal overview. *Nursing Praxis in New Zealand, 15*(1), 4-12.

Rai, K. (2002). Difficulties in cross-cultural mental health assessments. *Visions: British Columbia's Mental Health Journal, 9*, 28-31.

Redfield, R., Linton, R., & Herskovits, M. (1936). Memorandum for the study of acculturation. *American Anthropologist, 38*, 149-152.

Remennick, L. (2003). "I have no time for potential troubles": Russian immigrant women and breast cancer screening in Israel. *Journal of Immigrant Health, 5*(4), 153-163.

Remennick, L. (2004). Language acquisition, ethnicity and social integration among former Soviet immigrants of the 1990s in Israel. *Ethnic and Racial Studies, 27*(3), 431-454.

Ricoeur, P. (1992). *Oneself as another*. Chicago: University of Chicago Press.

Rivadeneyra, R., Elderkin-Thompson, V., Silver, R., & Waitzkin, H. (2000). Patient-centeredness in medical encounters requiring an interpreter. *American Journal of Medicine, 108*, 470-478.

Romanow, R. (2002). *Building on values: The future of health care in Canada*. Ottawa: Commission on the Future of Health Care in Canada.

Ross, C., Mirowsky, J., & Goldsteen, K. (1990). The impact of the family on health: The decade in review. *Journal of Marriage and the Family, 52*, 1059-1078.

Roter, D., & Hall, J. (1997). Patient-provider communication. In K. Glanz, F. Marcus Lewis, & B. Rimer (Eds.), *Health behavior and health education: Theory, research, and practice* (pp. 206-226). San Francisco: Jossey-Bass.

Ruesch, J., Jacobson, A., & Loeb, M. (1984). Acculturation and illness. *Psychology Monographs: General and Applied, 292*, 1-40.

Rumbaut, R. (1985). Mental health and the refugee experience: A comparative study of Southeast Asian Refugees. In T. C. Owen (Ed.), *Southeast Asian mental health: Treatment, prevention, service, training and research* (DHSS Publication No. ADM 85-1399, pp. 433-485). Washington, DC: U.S. Department of Health and Human Services.

Rumbaut, R. (1991). The agony of exile: A study of migration and adaptation of Indochinese refugee adults and children. In F. Ahearn & J. Athey (Eds.), *Refugee children: Theory, research and services*, (pp. 53-91). Baltimore: Johns Hopkins University Press.

Sabagh, G., & Bozorgmehr, M. (1987). Are the characteristics of exiles different from immigrants?: The case of Iranians in Los Angeles. *Sociology and Social Research, 71*, 77-84.

Satcher, D. (1999). The initiative to eliminate racial and ethnic health disparities is moving forward. *Public Health Reports, 114*(3), 283-287.

Sawyer, L., Regev, H., Proctor, S., Nelson, M., Messias, D., Barens, O., et al. (1995). Matching versus cultural competence in research. *Research in Nursing & Health, 18*, 557-567.

Schall, U. (1986). *Report on the result of a "survey of frail, elderly and needy German-speaking citizens in Ottawa-Carleton."* Ottawa, Canada: German-Speaking Alliance of Ottawa.

Schiller, P. (1987). *Biculturalism and psychological adjustment among Native American university students*. Unpublished doctoral dissertation, University of Utah, Utah.

Schor, E., Starfield, B., Stidley, C., & Hankin, J. (1987). Family health: Utilization and effects of family medicine. *Medical Care, 25*(7), 616-626.

Schreiber, R. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. Schreiber & P. Stern (Eds.), *Using grounded theory in nursing* (pp. 55-83). New York: Springer.

Schultz, S. (1982). How Southeast Asian refugees in California adapt to unfamiliar health care practice. *Health and Social Work, 7*, 148-156.

Schumacher, K., & Meleis, A. (1994). Transitions: A central concept in nursing. *Image: The Journal of Nursing Scholarship, 26*, 1119-1127.

Schwandt, T. (2001). *Dictionary of qualitative inquiry*. Thousand Oaks, CA: Sage.

Searight, H. (2003). Bosnian immigrants' perceptions of the United States health care system: A qualitative interview study. *Journal of Immigrant Health, 5*(2), 87-93.

Sechrest, L., Fay, T., & Hafeez Zaidi, S. (1972). Problems of translation in cross-cultural research. *Journal of Cross-Cultural Psychology, 3*(1), 49-56.

Shahideh, L. (2004). *The power of Iranian narratives: A thousand years of healing*. Dallas, TX: University Press of America.

Shapiro, J., & Saltzer, E. (1981). Cross-cultural aspects of physician-patient communication patterns. *Urban Health, 10*(10), 10-15.

Shaw-Taylor, Y. (2002). Culturally and linguistically appropriate health care for racial or ethnic minorities: Analysis of the US Office of Minority Health's recommended standards. *Health Policy, 62*, 211-221.

Sin, D., Svenson, L., Cowie, R., & Paul Man (2003). Can universal access to health care eliminate health inequalities between children of poor and nonpoor families? *American College of Chest physicians, 124*(1), 51-56.

Smith, J. (2001). Redesigning health care. BMJ, 322(26), 1257-1258. Retrieved June, 21, 2005, from http://www.bmj.com/cgi/reprint/322/7297/1257?ijkey=0be7f093388c54e2295d6864ce15572787529c27

Solis, A. (1981). Theory of biculturality. *Calmecac de Aztlan en Los , 2*, 36-42.

Spector, R. E. (2000). *Cultural diversity in health and illness.* Upper Saddle River, NJ: Prentice Hall.

Spradley, J. (1979). *The ethnographic interview*. New York: Holt, Rinehart & Winston.

Stanoch, P. (1999). Carrying cultural baggage, *World Traveler*, 48.

Statistics Canada. (1991). *Annual demographic statistics, 1991.* Ottawa, Ont: Statistics Canada.

Statistics Canada. (2002). *Annual demographic statistics, 2002.* Ottawa, Ont: Statistics Canada.

Statistics Canada. (2004). *Annual demographic statistics, 2004.* Ottawa, Ont: Statistics Canada.

Statistics Canada. (2006). *Annual demographic statistics, 2005.* Ottawa, Ont: Statistics Canada.

Stein, B. (1986). The experience of being a refugee: Insights from the research literature. In C. Williams & J. Westermeyer (Eds.), *Refugee mental health in resettlement countries* (pp. 3-23). Washington, DC: Hemisphere.

Stephens, E., Foote, K., Hendershot, G., & Schoenborn, C. (1994). Health of the foreign-born population: United States, 1989-1990. *Advance Data, 14*(214), 1-12.

Stern, N. (1980). Grounded theory methodology: Its uses and processes. *Image: The Journal of Nursing Scholarship, 12*(7), 20-23.

Stevens, S. (1995). Immigrant settlement: Health and social supports. In R. Masi, L. Mensah, & K. McLeod (Eds.), *Health and cultures: Exploring the relationships, programs, services and care* (pp. 277-292). Oakville, Canada: Mosaic.

Stevens, P., Hall, J., & Meleis, A. (1992). Narrative as a basis for culturally relevant holistic care: Ethnicity and everyday experiences of women clerical workers. *Holistic Nursing Practice, 6*(3), 49-58.

Stevenson, P., Thomas, J., & Romagoza, J. (2002, May). Building market share in the Latino community. *Health Care Financial Management*, 68-72.

Strafield, B. (2000). Is equity a scientific issue? *Western Journal of Medicine, 173*(1), 7.

Strauss, A. (1987). *Qualitative analysis for social scientists*. Cambridge, UK: University of Cambridge Press.

Strauss, A., & Corbin, J. (1990). *Basic of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, CA: Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Streubert, H., & Carpenter, D. (1999). *Qualitative research in nursing: Advancing the humanistic imperative* (2nd ed.). Philadelphia: Lippincott.

Sue, S., & Sue, D. (1987). Cultural factors in the clinical assessment of Asian Americans. *Journal of Consulting and Clinical Psychology, 55*, 479-487.

Sullivan, Z. (2001). *Exiles memories: Stories of Iranian diaspora*. Philadelphia: Temple University Press.

Sundquist, J., Bayard-Burfield, L., Johansson, L., & Johansson, S. (2000). Impact of ethnicity, violence, and acculturation on displaced migrants: Psychological distress and psychosomatic complaints among refuges in Sweden. *Journal of Nervous and Mental Disease, 188*(6), 357-365.

Sung, B. (1985). Bicultural conflicts in Chinese immigrant children. *Journal of Comparative Family Studies, 26*, 255-269.

Supples, J., & Smith, M. (1995). East and West of Main Street: Racism in rural America. *Public Health Nursing, 12*(4), 235-241.

Suschnigg, C. (2001). Reforming Ontario's primary health care system: One step forward, two steps back? *International Journal of Health Services, 31*, 91-103.

Szapocznik, J., & Kurtinez, W. (1978). Acculturation, biculturalism, and adjustment among Cuban Americans. In A. M. Padilla (Ed.), *Acculturation: Theory, models and some new findings*. Boulder, CO: Westview.

Szapocznik, J., Kurtinez, W., & Fernandez, T. (1980). Bicultural involvement and adjustment in Hispanic-American youths. *International Journal of Intercultural Relations, 4*, 353-365.

Szapocznik, J., Scopetta, M., Kurtinez, W., & Aranalde, M. (1978). Theory and measurement of acculturation. *Interamerican Journal of Psychology, 12*, 113-130.

Tanahashi, R. (1978). Health services coverage and evaluation. *Bulletin of the World Health Organization, 56*, 295-303.

Teske, R., & Nelson, B. (1974). Acculturation and assimilation: A clarification. *American Ethnologist, 1*, 351-367.

Thomas, J., & Penchansky, R. (1984). Relating satisfaction with access to utilization of services. *Medical Care, 22*, 553-568.

Thomas, R., & Woodruff, M. (1999). *Building a house for diversity: How a fable about a giraffe and an elephant offers new strategies for today's workplace*. New York: AMACOM.

Thomas, T. (1995). Acculturative stress in the adjustment of immigrant families. *Journal of Social Distress and the Homeless, 4*, 131-142.

Timmins, C. (2002). The impact of language barriers on the health care of Latinos in the United Sates: A review of the literature and guidelines for practice. *Journal of Midwifery and Women's Health, 47*(2), 80-96.

Toumishey, H. (1995). Multicultural health care: An introductory course for health professionals. In R. Masi, L. Mensah, & K. McLeod (Eds.), *Health and cultures: Exploring the relationships, policies, professional practice and education* (pp. 113-138). Oakville, Canada: Mosaic.

Tran, T. (1990). Language acculturation among older Vietnamese refugee adults. *The Gerontologist, 30*(1), 94-99.

Tripp-Reimer, T., Brink, P., & Saunders, J. (1984). Cultural assessment: Content and process. *Nursing Outlook, 32*(2), 78-82.

United Nations High Commissioner for Refugees (1995). *Statistices*. Retrieved June 21, 2005, from http://www.unhcr.org/statistics.html

United Nations High Commissioner for Refugees (2002a). *Refugees by numbers.* Retrieved June 21, 2005, from http:// www.unhcr.ch/cgi-bin/texis/vtx/home

United Nations High Commissioner for Refugees (2002b). *World refugees survey.* Retrieved June 21, 2005, from http://. www.refugees.org/world/articles/wrs02-americas2.cfm

Ventres, W., & Gordon, P. (1990). Communication strategies in caring for the underserved. *Journal of Health Care for the Poor and Underserved, 1*(3), 305-314.

Vinokurov, A., Birman, D., & Trickett, E. (2000). Psychological and acculturation correlates of work status among Soviet Jewish refugee in the United States. *International Migration Review, 34*(2), 538-559.

Vissandjee, B., Carignan, P., Gravel, S., & Leduc, N. (1998). Promotion de la santé en faveur des femmes immigrant au Quebec. *Revue epidemiologique et santé public, 43*, 124-133.

Vreeland, H. (1957). *Iran*. New Haven: human Relations Area Files.

Walker, P., & Jaranson, J. (1999). Refugee and immigrant health care. *Travel Medicine*, 4, 1103-1120.

Waxler-Morrison, N., Anderson, J., & Richardson, E. (1990). *Cross-cultural Caring: A handbook for health professionals in Western Canada* Vancouver, Canada: University of British Columbia Press.

Waxler-Morrison, N., Anderson, J., Richardson, E., & Chambers, N. (2005). *Cross-cultural caring* (2nd ed.). Vancouver, Canada: University of British Columbia Press.

Weber, M. (1968). *Economy and society* (Vol. 1). New York: Bedsminster Press.

Weber, L., Carter, A. (2003). *The social construction of trust*. NY: Kluwer Academic/ Plenum Publisher.

Westermeyer, J. (1989). *Mental health for refugees and other migrants: Social and preventative approaches*. Springfield, IL: Charles C. Thomas.

Westermeyer, J., Callies, A., & Neider, J. (1990). Welfare status and psychosocial adjustment among 100 Hmong refugees. *Journal of Nervous and Mental Disease, 178*, 300-306.

Whalen, D. (1999). Cultural sensitivity: A matter of respect. *Canadian Nurse, 95*(9), 43.

Wheeler, M. (1995). *Diversity: Business rationale and strategies*. New York: Conference Board.

Wiking, E., Johansson, S., & Sunduist, J. (2004). Ethnicity, acculturation, and self reported health. A population based study among immigrants from Poland, Turkey, and Iran in Sweden. *Journal of Epidemiology and Community Health, 2*(58), 574-582. Retrieved October 20, 2006, from http://jech.bmj.com/cgi/content/abstract/58/7/574

Willamson, D., & Fast, J. (1998). Poverty and medical treatment: When public policy compromises accessibility. *Canadian Journal of Public Health, 89*, 120-124.

Willgerodt, M., Miller, A., & McElmurry, B. (2002). Becoming bicultural: Chinese American women and their development. *Health Care for Women International, 23*(5), 467-480.

Williams, C., & Berry, J. (1991). Primary prevention of acculturative stress among refugees. *American Psychologist, 46*, 632-641.

Wolf, E. (2001). Providing culturally appropriate care: A tale of two hospitals. *Health Care Executive, 16*(2), 11-17.

Woloshin, S., Bickell, N., Schwartz, L., Gany, F., & Welch, H. (1995). Language barriers in medicine in the United States. *Journal of the American Medical Association, 273*(9), 724-728.

Woloshin, S., Schwartz, M., Katz, S., & Welch, H. (1995). Is language a barrier to the use of preventive services? *Journal of General Internal Medicine, 12*, 472-477.

Yamnilan, S., & McLean, G. (2001).Theories supporting transfer of training. *Human Resources Development Quarterly, 12*, 195-207.

Young, D., Spitzer, D., & Pang, F. (1999). *Understanding the health care needs of Canadian immigrants*. Edmonton, Canada: Report for the Prairie Centre of Excellence for Research in Immigration and Integration.

Yuan, L., Rootman, I., & Tayeh, A. (1999). *Health status and health care access for the Arab community in Toronto: A pilot study to access health needs*. Toronto: Centre of Excellence for Research on Immigration and Settlement (*CERIS Research Report)*.

Zambrana, R. (1987). A research agenda on issues affecting poor and minority women: A model for understanding their health needs. *Women and Health, 12*, 137-160.

Zambrana. R., & Silva-Palacios, V. (1989). Gender differences in stress among Mexican immigrant adolescents in Los Angeles, California. *Journal of Adolescent Research, 4*, 426-442.

Ziglio, E., Hahard, S., McMahon, L., Harvey, S., & Levin, L. (2000). Principles, methodology and practices of investment for health. *Promotion & Education, 7*(2), 4-15.

Zimbardo, P. (1992). *Psychology and life*. New York: Harper Collins.

APPENDIX A

Letter of Invitation (Persian and English)

NEEDED: IRANIAN IMMIGRANTS

You are invited to participate in a study "The Experience of Iranian Immigrants who Access to Canadian Health Care Services." The purpose of this study is to understand the processes by which Iranian immigrants learn to access health care services in Canada. All information will be kept confidential. You do not have to be in this study if you do not wish to be. You can withdraw from the study at any time. There will be no harm or direct benefit to you by participating in this study.

To participate in this study you should meet the following criteria:

- Eighteen years of age and above at the time of immigration
- Speak Persian (Farsi) and/ or English
- Hold immigrant or refugee status (Iranians who have come to Canada as students, tourists or visitors cannot participate in this study)
- Have used Canadian health care services
- Live in Edmonton, Canada

If you are interested in taking part in this study, please contact me at the address below.

Thank you for your cooperation and time.

Regards

Mahadieh Dastjerdi, BScN, RN, MScN, PhD Candidate
International Institute for Qualitative Methodology (IIQM)
Sixth Floor, University Extension Centre, U of A
8303, 112 Street , Edmonton, AB, Canada T6G 2T4
Phone: 492-6413
Email: mahdieh@ualberta.ca

APPENDIX B

Information Letter (Persian and English)

Research Title: The Experience of Iranian Immigrants who Access to Canadian Health Care Services

Investigator: Mahdieh Dastjerdi, BScN, RN, MScN, PhD Candidate
International Institute for Qualitative Methodology (IIQM)
Sixth Floor, University Extension Centre, U of A
8303 - 112 Street
Edmonton, AB, Canada T6G 2T4
Phone: 492-6413
Email: mahdieh@ualberta.ca

Supervisors: Dr. Karin Olson, Associate Professor, University of Alberta, Faculty of Nursing
Dr. Linda Ogilvie, Associate Professor, University of Alberta, Faculty of Nursing

Purpose of this study: The goal of this study is to learn more about how Iranian immigrants learn to use health care services in Canada.

Background: Immigrants have a great amount of stress when trying to build a new life in their host countries. One of the most important sources of stress is illness. To obtain treatment health care services are needed, but immigrants sometimes find this to be difficult.

Procedures and confidentiality: If you choose to take part, the researcher will meet with you for 1 - 2 hours. During this time, the researcher will ask you to describe your experiences with health care services in Canada. The researcher may phone you to schedule 1 or 2 additional interviews. The purpose of these interviews will be to clarify issues raised by other participants. The interview can be in Persian (Farsi) or English, whichever you would prefer. Interviews will be tape-recorded and typed. All names and

Initials_____

other identifying information will be removed from the typed copy. All of your information and experiences will be confidential. The researcher will remove your name and any identifying information from the tape of the interviews. All tapes will be kept in a locked cabinet and be separate from your consent form and demographic information. Only the researcher and her thesis committee members will have access to your information. In final reports, the researcher might use your actual words but will never use your name. Your name will not appear in any publication or presentation. In future study, if the researcher needs to use this information again, she will submit a request to the appropriate ethics review committee.

Freedom to withdraw: You do not have to be in this study if you do not wish to be. You can withdraw from the study at any time.

Benefits and risks: There will be no harm or direct benefit to you by participating in this study. However, the researcher hopes that the information obtained will be used to make Canadian health care services fully accessible to immigrants. You are welcome to know about the results of study if you wish.

Additional contacts: If you have any concerns about this study, you may contact Dr. Kathy Kovacs-Burns, Director of Research, Faculty of Nursing, University of Alberta at 492-3769. Dr. Kathy Kovacs-Burns has no affiliation with this study.

Initials_____

APPENDIX C

Consent Form (Persian and English)

Research Title: The Experience of Iranian Immigrants who Access to Canadian Health Care Services

Investigator: Mahdieh Dastjerdi, BScN, RN, MScN, PhD Candidate

Phone: 492-6413 Email: mahdieh@ualberta.ca

Supervisors: Dr. Karin Olson, Associate Professor, University of Alberta, Faculty of Nursing

Dr. Linda Ogilvie, Associate Professor, University of Alberta, Faculty of Nursing

Do you understand that you have been asked to be in a research study?	Yes No
Have you read and received a copy of the attached Information Letter?	Yes No
Do you understand the benefits and risks involved in taking part in this research study?	Yes No
Have you had an opportunity to ask questions and discuss this study?	Yes No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect you or your life, job in the community.	Yes No
Has the issue of confidentiality been explained to you?	Yes No
Do you understand who will have access to your records?	Yes No
Do you understand that the data you provide for this study may be analyzed in future studies?	Yes No
Would you like a report of the research findings when the study is done?	Yes No

This study was explained to me by:_____ Date: _____

I agree to take part in this study.

_____ _____

Signature of Research Participant Witness (if available)

_____ _____

Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____

Signature of Researcher Printed Name

APPENDIX D.1

Demographic Data

Interview Date _____

Code Number _____

Age _____ Gender _____

Marital Status _____

Family size before immigration _____

Family size after immigration _____

Language _____

Ethnicity _____

Educational Background _____

Occupation _____

Date of immigration to Canada _____

Immigration Status _____

APPENDIX D.2

Demographic Data

AGE	GENDER	ARRIVAL IMMIGRATION STATUS	YEARS IN CANADA	EDUCATION
34	M	Immigrant	7 Years	Bachelor
30	M	Immigrant	5 Years	Master
25	M	Refugee	3 Years	Bachelor
39	M	Unknown	13 Years	Master
42	M	Unknown	10 Years	Master
27	M	Immigrant	3 Years	Bachelor
49	F	Immigrant	14 Years	High School
39	F	Immigrant	7 Years	High School
45	F	Immigrant	15 Years	Doctorate
40	F	Refugee	12 Years	Master
27	F	Unknown	4 Years	High School
28	F	Unknown	3 Years	High School
30	F	Refugee	3 Years	Bachelor
44	F	Immigrant	8 Years	Bachelor
38	F	Unknown	4 Years	Master
25	F	Immigrant	2 Years	Bachelor
32	F	Refugee	7 Years	Master

APPENDIX E

Initial Interview Questions

Thinking back to the first time you wanted to access health care services in Canada.

1. Tell me about your experiences after coming to Canada. How was that time like for you?
2. Tell me about a time you experienced a health problem as an immigrant. What was that time like for you? How did you find it?
3. Tell me, how did you overcome with it?
4. As you think about your experiences with Canadian health care services, tell me what you have experienced as an immigrant?
5. How are things for you now?
6. What has been the most challenging experience about accessing Canadian health care services as an immigrant?
7. Can you tell me what you have learned from this experience?
8. Is there anything else about your access to Canadian health care services you would like to share with me?

APPENDIX F

Equal Persian Words

a. 1) *khod raa faraamosh kardan* (p.74)

خود را فراموش کردن

a. 2) *khod raa aakahar list gozashtan* (p.74)

خود رو آخر لیست گذاشتن

b. 1) *goom shodan* (p.76)

گم شدن

b. 2) *sar dar nayaa wordan* (p.76)

سر در نیاوردن

b. 3) *beyne zamin va hawaa bodan* (p.76)

بین زمین و آسمان بودن

b. 4) *sar dar goomi* (p.76)

سر در گمی

b. 5) *sar gar dooni* (p.76)

سرگردونی

b. 6) *nemidoni kojay in system hasti* (p.76)

نمیدونی کجای این سیستم هستی

c. 1) *ehsaase naa omidi kardan* (p.82)

احساس نا امیدی کردن

c. 2) *naa omid bodan* (p.82)

نا امید بودن

c. 3) *naa omid shodan* (p.82)

نا امید شدن

c. 4) *ghate omid kardan* (p.82)

قطع امید کردن

c. 5) *ghate omid shodan* (p.82)

قطع امید شدن

c. 6) *az hame ja va az hame chiz ghate omid kardan* (p.82)

از همه جا و همه کس قطع امید کردن

c. 7) *az hame ja va az hame chiz ghate omid shodan* (p.82)

از همه جا و همه کس قطع امید شدن

d. 1) *ehsaase bichaaregi kardan* (p.82)

احساس بیچارگی کردن

d. 2) *ehsaase naa tavaani kardan* (p. 82)

احساس ناتوانی کردن

d. 3) *raah be hich jaaee nadaashtan* (P.82)

راه به هیچ جایی نداشتن

d. 4) *ehsaase darmaandegi kardan* (p.82)

احساس درماندگی کردن

e. 1) *nemidonestam koja beram* (p.82)

نمیدونستم کجا برم

e. 2) *nemidonestam be ki moraaje bekonam* (p.82)

نمیدونستم به کی مراجعه بکنم

e. 3) *nemidonestam baa ki harf bezanam* (p.82)

نمیدونستم با کی حرف بزنم

e. 4) *nemidonestam chiro baayad be ki begam* (p.82)

نمیدونستم چی رو به کی بگم

e. 5) *mesle in ke tu taariki raah miraftam* (p.82)

مثل اینکه تو تاریکی راه میرفتم

e. 6) *man hichi nemidonestam* (p.82)

من هیچی نمیدونستم

e. 7) *az hich chiz sar dar rnemiowordam* (p.82)

از هیچی سر در نمیوردم

f. 1) *etemaad nakardan* (p.90)

اعتماد نکردن

f. 2) *etminaan nakardan* (p.90)

اطمینان نکردن

f. 3) *motmaeen naboudan* (p.90)

مطمئن نبودن

g. 1) *khejaalat* (p.99)

خجالت

h. 1) *ghorour* (p.99)

غرور

i. 1) *soale ziyaad yaa bi jaa kardan* (p. 99)

سئوال زیاد یا بیجا کردن

j. 1) *masasele kkhosoussi* (p.99)

مسئله خصوصی

k. 1) *dar meyoon gozaashtan* (p. 99)

در میون گذاشتن

l. 1) *chizi nemidonestam* (p. 99)

چیزی نمیدونستم

l. 2) *kasi chizy be maa nagoft* (p.99)

کسی بما چیزی نگفت

m. 1) az *dast daadan etebar* (p.100)

از دست دادن اعتبار

m. 2) *khejaalat keshidan* (p.100)

خجالت کشیدن

m. 3) *hefze aaberoo kardan* (p.100)

حفظ آبرو کردن

m. 4) *hefze hoviyat kardan* (p.100)

حفظ هویت کردن

n. 1) *etemaad kardan* (p.105)

اعتماد کردن

n. 2) *ghaboul kardan* (p.105)

قبول کردن

Note: English translations of these words can be found on the pages indicated above.